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VOLUME 56

FEBRUARY 1941

NUMBER 2

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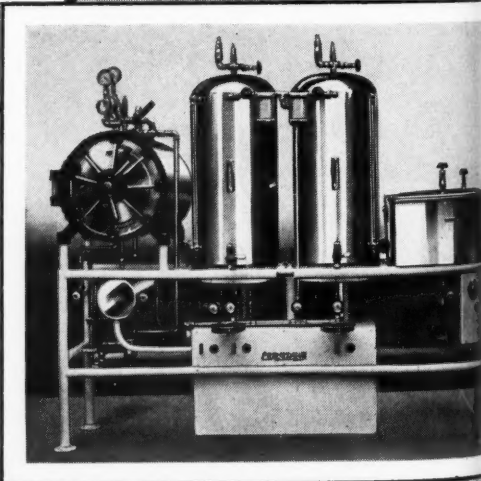


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Just in Passing—

SO MANY hospitals today are planning to remodel and expand their facilities that the editors have decided to present a portfolio of recent examples of such work. This will be the *pièce de résistance* of the March building and equipment issue. New additions of hospitals from coast to coast will be available for your inspection and study.

THE tabulating machines are whirring (if, indeed, such machines do whirl) and in a steady stream pour forth data on the incomes of various hospital employes. The first study in this second series, publication of which will begin next month, will deal with orderlies and ward aids.

SO MANY small hospitals seem to be seriously concerned with the difficulties involved in obtaining adequate medical records that the Small Hospital Forum for March will be devoted to that subject.

TRENDS in kitchen equipment will be the feature article in the Food Service department next month while the Pharmacy section will describe a remodeled pharmacy at Saginaw General Hospital, Saginaw, Mich.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent		
Supt. of Nurses		
Surg. Supervisor		
Dietitian		
Housekeeper		
Pharmacist		
Engineer		
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Return to		

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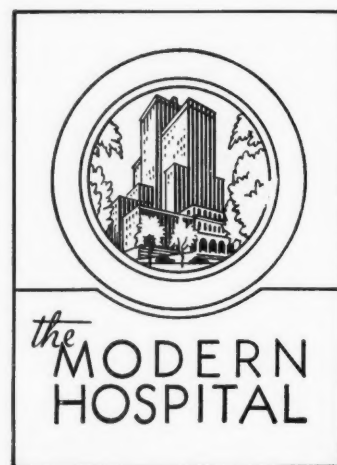
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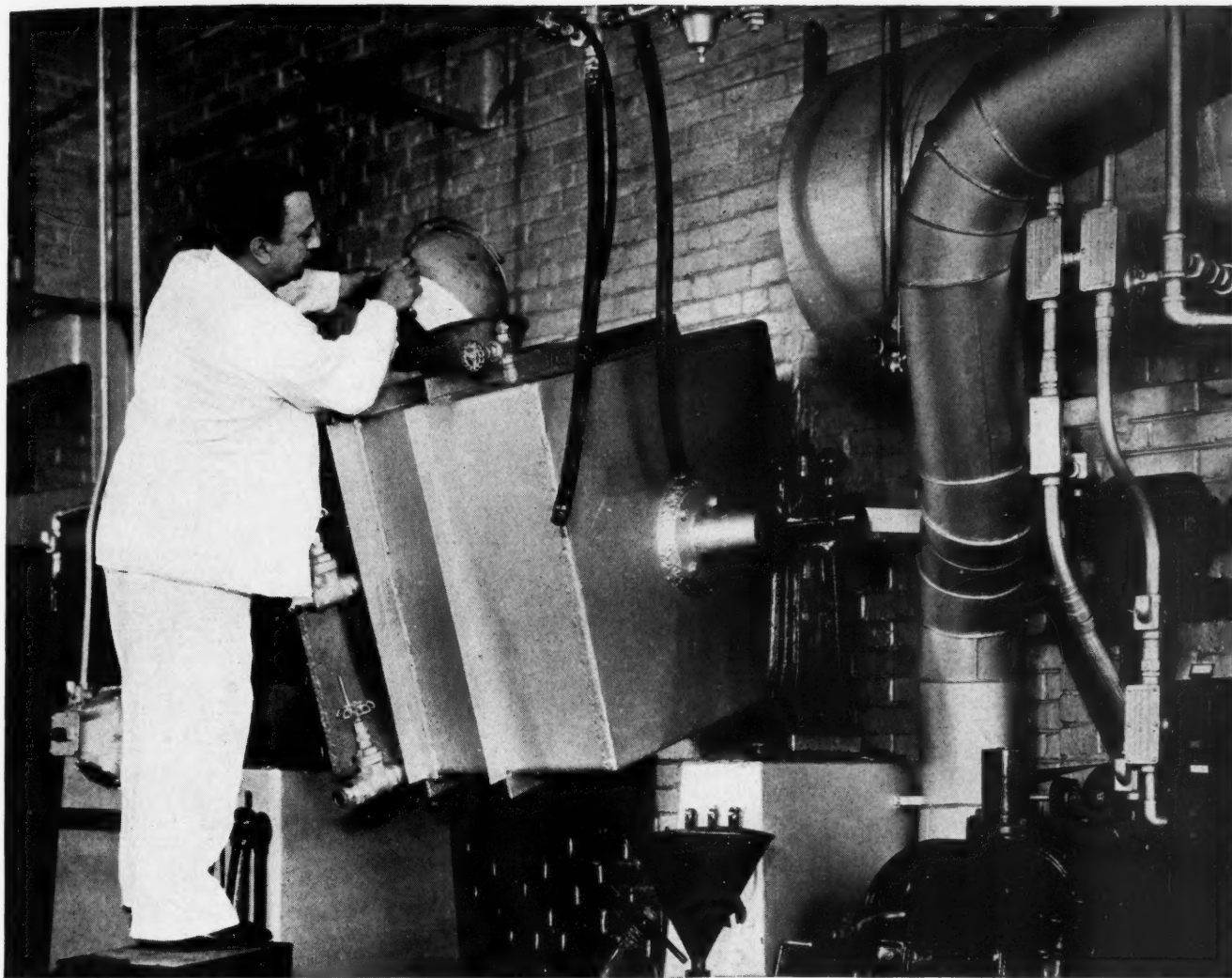


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Something New In Hobbies

• Botanical roentgenology, that is what Mary Haynes of Wilkes-Barre General Hospital in Wilkes-Barre, Pa., calls it, and she should know. Your Roving Reporter wishes everyone could see the example of it that stands alongside his typewriter—a delicate flower print that was reproduced, well, he'll let Miss Haynes tell the story herself.

"It all started in 1932," she says, "when at a national x-ray technicians' convention I saw a negative of a calla lily. Upon returning home, I immediately began acquiring a technic of x-raying flowers. It took about a year of experimenting, for flowers are of such delicate composition that an extremely low voltage and low milliamperage are necessary. The background of the negative from which the prints are made must be dark, yet it should not obscure the fine detail and outlines of the flowers, such as stamens, pistils, veins in the leaves and tiny buds. Having obtained this detail on the negative, which can be transferred to prints, the hidden detail is brought to view because of the penetrating power of the x-ray."

What Miss Haynes might be too modest to add is that some of her floral prints were exhibited at the New York Flower Show and at the New York World's Fair in "Gardens on Parade."

A Word to the Patient

• Nursing service and food are generally the most common sources of complaints by patients. One way to eliminate these, or at least to reduce their number, is to gain the cooperation of each individual, urging him to make known his dissatisfaction at once so that the situation can be rectified.

This leads your Roving Reporter to describe the little folder on nursing service that is given to each patient after his admission to Toledo Hospital, Toledo, Ohio. One look at the cover with its procession of young nurses each with her candle, and sympathetic accord is created. Add to this the brief excerpt from the Florence Nightingale pledge—"With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care"—and the conquest is complete.

Inside is a printed message addressed personally to the patient and signed by the head nurse and the assistant head nurse. "It has long been the policy of



A sample of Miss Haynes' unusual hobby of botanical roentgenology is this x-ray print of a day lily.

Toledo Hospital," one reads, "to give the very best in nursing care to its patients for whom the institution exists.

"However, realizing that the service cannot be satisfactory at all times unless there is a spirit of mutual cooperation between the patient and the staff, we ask your valued assistance. May we enlist your help in maintaining a high standard of nursing care to you by requesting that you give us your comments and suggestions as soon as possible in order that we may correct any dissatisfaction promptly.

"Executives from the nursing office will call on you from time to time to inquire if you are pleased with your service. My assistant and I welcome an opportunity to make desirable adjustments for your pleasure while you are our guest."

It would be surprising, indeed, if this plea for cooperation did not prove helpful. Wilson L. Benfer, the superintendent, attests that it already has.

It Cut Mailing Costs

• The distribution of hospital literature, such as annual reports and booklets, involves considerable expense, unfortunately. Imagine, for example, the cost of mailing some 14,000 bulletins, each of which requires three cents' postage.

This is precisely the problem that

faced the Lancaster County Hospital, Lancaster, Pa., in connection with "Within These Walls." Incidentally, what an attractive booklet that is! In consequence, the mails were used sparingly and the services of Boy Scouts were enlisted to deliver some 8000 copies. Even in outlying sections the Scouts or some similar organization assisted so that out of the entire edition only approximately 2000 copies had to be mailed. In return for their work, the Scouts received generous publicity in the local papers with pictures showing a boy delivering a book to a home.

Incidentally, the addressing and most of the inserting were done by N.Y.A. girls, hospital auxiliary members and the Boy Scouts.

War Work at Cambridge

• What's this hum of activity about the Cambridge Hospital, Cambridge, Mass.? Always a busy spot, during recent months it has become a center of war relief work. When the kitchen facilities were revamped certain rooms became available and these were turned over to the British War Relief workers last fall. They started by occupying them two days a week. Since that time, however, their activities have increased until now they are using the rooms five days and three evenings.

Some idea of what has been accomplished is revealed by Dr. A. G. Engelbach, director. "Just before Christmas," he tells us, "they sent to England two mobile kitchens, two hospital beds, 135 knitted articles, 150 surgical bandages and nearly 400 new garments. They are now receiving contributions for a third rolling kitchen."

War work at Cambridge does not end there. An auditorium in the nurses' residence, accommodating from 400 to 450 persons, is about to be taken over by the local chapter of the American Red Cross for a course in home hygiene and care of the sick. In the event of catastrophe or depletion of the regular nursing force these volunteers may be called upon to assist the regular nursing staff. Who knows? They are there anyway, should they be needed. It is also possible that before many weeks have passed a course of the Volunteer Nurses' Aid Corps (Pink Lady) will be established.

Because their town is close to the Atlantic, the problem of defense becomes real to the hospital people of Cambridge.

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¹Ambler, Arthur C.: *North Carolina M. J.* 1:244 (May) 1940

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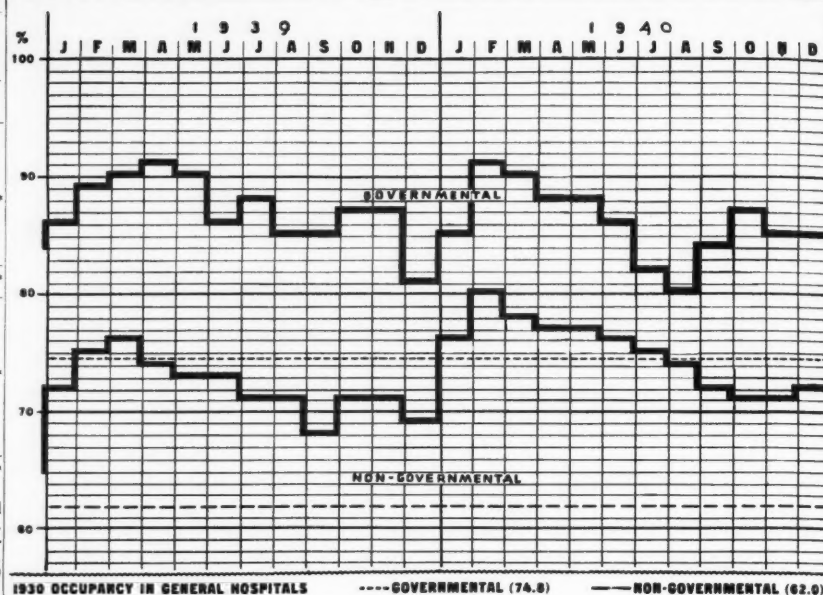
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HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals		1940		1939	
	Hosp. ¹	Beds ²	Dec.	Nov.	Dec.	Nov.
Governmental:						
New York City.....	17	10,530	98*	98	92	92
New Jersey.....	5	2,285	88*	88*	93	91
N. and S. Carolina.....	20	2,632	66*	69	67	70
New Orleans.....	2	3,533	84*	82	71	106*
San Francisco.....	3	2,255	101*	101	95	96
St. Paul.....	1	850	72*	69*	62	67
Chicago.....	2	3,500	86	88	88	89
Total ⁴	50	25,585	85*	85*	81	87*
Nongovernmental:						
New York City ³	68	15,194	69*	69*	71	73
New Jersey.....	56	8,111	73*	73*	66	68
N. & S. Carolina.....	108	7,460	62*	64	63	65
New Orleans.....	6	1,192	70*	75	67*	74*
San Francisco.....	16	3,178	75*	75	71	75
St. Paul.....	9	1,129	74*	75*	77	69
Chicago.....	30	6,122	65*	69	62	65
Cleveland.....	6	1,200	75*	80	74	78
Total ⁴	299	43,586	70*	72*	69*	71*

¹Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. ²Excluding bassinets, usually. ³General hospitals only. ⁴Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1010 of The Eighteenth Hospital Yearbook.



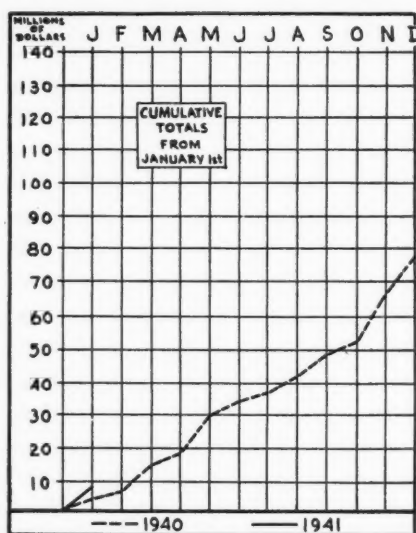
Occupancy Hits 75 Per Cent for 1940

Preliminary figures on the occupancy of nongovernmental general hospitals indicate a seasonal drop to 70 per cent in December from 72 per cent in November. This is slightly above the 69 per cent figure reported for December 1939 and well above previous Decembers, which were as follows: 66 per cent (1938); 65 per cent (1937); 66 per cent (1936); 59 per cent (1935); 56 per cent (1934), and 53 per cent (1933).

For the twelve months of 1940, the figures now available give an average occupancy for the reporting nongovernmental hospitals of 75 per cent as compared with 72 per cent for 1939. In 1938 these hospitals had a 70 per cent occupancy; in 1937, the figure was 71 per cent; in 1936 it was 66 per cent; in 1935, 61 per cent; in 1934, 58 per cent, and in 1933, 54 per cent.

In the governmental general hospitals the December occupancy remained at 85 per cent, the same figure reported for November. This gives an average occupancy for the whole year (subject to minor correction upon receipt of additional reports) of 86 per cent. This is a slight drop from the 87 per cent reported for 1939. The figures for these hospitals for 1933 to 1938, inclusive, were 86, 88, 86, 87, 82 and 83 per cent, respectively. A sharp drop in occupancy to 82 per cent was registered in 1937 when the country was experiencing a brief boom but the slump in

HOSPITAL CONSTRUCTION



1938 and 1939 again crowded the governmental hospitals.

When the figures for governmental and nongovernmental hospitals are considered together it is apparent that the total number of patients who use hospitals has grown remarkably since 1933. In that year governmental hospitals recorded 86 per cent occupancy and nongovernmental hospitals, 54 per cent. In 1940 the governmental hospitals were still filled to 86 per cent of capacity while the nongovernmental in-

stitutions had increased to 75 per cent. And both groups of institutions had increased their bed capacities.

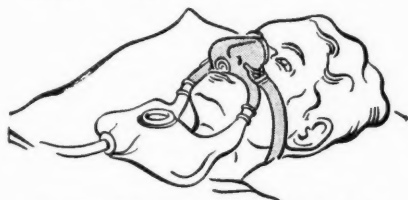
Hospital construction during the period from December 16 to January 13 stepped forward rapidly. A total of 60 new projects was reported, with 57 of them giving \$8,193,000 as estimated costs. There were six new hospitals to cost \$1,275,000. Forty-one additions to existing institutions were announced of which 38 gave cost figures totaling \$5,705,000. Seven alterations were listed at \$343,000 and six nurses' homes, at \$870,000.

The general wholesale price index of the *New York Journal of Commerce* advanced from 81.7 to 83.3 in the period from December 14 to January 18. Grain prices went up during this period from 66.2 to 68.6; food advanced more sharply from 68.1 to 72.2 and textiles rose slightly from 75.4 to 75.7.

Fuel also moved up from 84.8 to 85.5. Building materials, on the other hand, showed a slight decline from 113.9 to 112.9. On August 17 the price of building materials stood at 98.4 and then started a spectacular advance to a high of 117.1 on October 26. The index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* moved from 203.5 to 205.9 in the period from December 16 to January 20.

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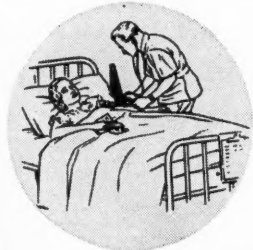
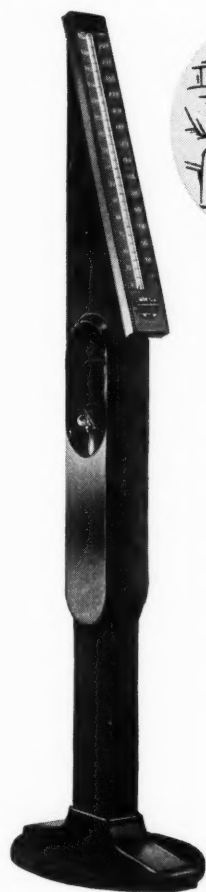
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SMALL HOSPITAL QUESTIONS

Aid to Osteopaths?

Question: Should a hospital ever do x-ray or laboratory work for an osteopath? If the hospital does not do this kind of work and the osteopath then succeeds in having one of the physicians do it in his office, what attitude should the hospital take toward this doctor?—M.E.P., Ill.

ANSWER: The x-ray and laboratory service in any hospital should be used only by those who are thoroughly qualified to interpret and to apply the results of examinations. This, therefore, presupposes that laboratory and x-ray services be restricted entirely to graduates of medicine with the M.D. degree. The hospital should deal only with regular M.D.'s in this respect.

If a doctor in private practice chooses to give osteopaths and chiropractors clinical and x-ray service through his private office, this is a matter of individual privilege. Such practice is likely to lower his standard of ethics among his confreres and, at the same time, might have some effect upon his appointment to the medical staff of a hospital. The hospital, however, has no jurisdiction over this matter if it occurs outside of the institution.—MALCOLM T. MACEachern, M.D.

Who Shall Serve Trays?

Question: In hospitals that have central food service, who is responsible for delivery of trays to patients when the hospital has but one dietitian and she remains in the kitchen to supervise the "setting up" of the next load of trays?—N.R., Ohio.

ANSWER: I believe that the nurse supervisor should be responsible for the distribution of trays to the patients. I also think that this work should be done by the nursing department, either nurses or nurse aids, because this arrangement reduces the number of dietary employees required at "peak hours" and also makes the nurses more mindful of the advisability of adjusting back rests and arranging tables before the trays are distributed.—ELIZABETH H. TUFT.

Charging for Oxygen

Question: How should we charge for oxygen given by nasal catheter—by the day or by the tank? How much?—O.M.G., Wis.

ANSWER: In our own institution, where the oxygen turnover is large, we charge by the tank, the price being double the cost of the tank. This means that the patient pays approximately \$5 per day. In smaller institutions, where oxygen is used in smaller volume or the price of oxygen is higher, I would recommend that a charge of \$7.50 per day be made, with proper consideration for part-day usage.—M. H. BARKER, M.D.

Conducted by Gladys Brandt, R.N.,
Children's Free Hospital, Louisville,
Ky.; Alloys F. Branton, M.D., Will-
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liam J. Donnelly, Princeton Hospi-
tal, Princeton, N. J., and others

A.C.S. Accreditation

Question: Should our hospital strive to become accredited by the American College of Surgeons or should we continue without accreditation? Will lack of accreditation eventually affect our status if the government provides hospitalization for its wards or employees in nongovernmental hospitals? When group hospitalization is introduced in our community will lack of accreditation affect us? Our hospital is one of two located in a primarily rural community of 10,000. The other institution is accredited. Our hospital is not accredited because our board does not believe in a formally organized staff; in fact, the constitution does not provide for a staff.—U.F., Neb.

ANSWER: Every hospital, no matter how small, should make accreditation its goal. I do not believe that lack of accreditation will cause a hospital to be eliminated but I do believe that the hospital that is accredited will have a better chance to be first choice. The matter of group hospitalization will depend on the requirements of the group hospitalization organization as to whether member hospitals must be accredited. So far it has not been generally necessary. Your board needs education regarding staff organization and, if necessary, your constitution should be changed to provide for an organized staff.—A. F. BRANTON, M.D.

Collecting for Care of Transients

Question: What are we to do when a transient is brought to the hospital? Whom shall we hold responsible for the hospitalization? In some cases we hold the county where the patient was found responsible, but not every county will take care of such cases. In our case the city is of no help. Is there any federal law covering these cases or has every state a fund for this purpose?—Sr. M.J., Tex.

ANSWER: This question cannot be answered in the same way for all communities and, unfortunately, even in localities that are aided by laws covering this problem difficulties are still encountered in collecting hospital bills for non-resident emergency cases.

Every state should have a lien law that would enable the hospital to collect its bill in cases where someone can be held liable for the patient's injury. In some states there are provisions in law where-

by a portion of the state's income from automobile licenses is used to pay hospitals for the care of automobile accident cases, if collection cannot be made from the patient.

The superintendent whose hospital is threatened with a loss in the care of an indigent nonresident should confer with the local welfare authorities as to the possibility of collecting the hospital bill from the welfare district in which the patient has legal residence. In certain states, such collections are regularly made for patients who are hospitalized away from their places of settlement but are still within the same state. In a few instances it is possible to make such collections across state lines.

It should be added that in some states, New York, for instance, it is possible for a hospital to apply to state welfare authorities to have an out of state patient made a "state charge." There should probably be a provision in the welfare law of every state making the state itself responsible for the support of indigent nonresidents until such time as state authorities can return them to their places of legal residence.—C. W. MUNGER, M.D.

News That's Fit to Print

Question: What news about a small hospital can properly be published in local newspapers?—B.B., Ind.

ANSWER: Most of the news published in the small town newspaper has a close personal interest to the people of that town. It would seem to be the hospital's job to provide those small details, such as the number of births occurring during regular intervals and the number of operations and patients per day, particularly if they are given in the form of a comparative study.

Personal items are, of course, of great interest but have to be handled with extreme caution. Cooperation should, however, be given to both the newspaper and the patient when the patient desires publication of the announcement of a birth or even of his operation.

The less specific details should also be given some attention. For instance, the future plans of a hospital should be given wide publication. The attendance of staff members at the various professional meetings is another item of interest. One of the state hospital associations conducts an "It's a Fact" or "Did You Know" column. This is an excellent idea, especially if the insertions are regular and in approximately the same location in the paper.—WILLIAM J. DONNELLY.

LOOKING FORWARD

Educating Department Heads

HOW seriously do you take the opportunities that are now available for further education of your department heads? The answer to this question, of course, depends in part upon the situation of each individual hospital. Many institutions that can afford it send their administrators and department heads to institutes and to the more significant conventions with full pay and with all or the major part of the expenses borne by the institution. Others cannot do so much but allow full pay and meet a share of the expenses. Still others seem to show no interest whatever in the professional advancement of department heads.

One Midwestern hospital made a rather remarkable record this past year. It sent 14 department heads to the Tri-State Hospital Assembly in Chicago and six department heads or administrative interns to the American Hospital Association Institute at the University of Chicago for the two weeks' course.

Of course, there are limits beyond which wise administration cannot go. There are so many meetings nowadays that it sometimes becomes difficult to keep things running smoothly in the hospital if an attempt is made to cover them all. But the wise board of trustees will set aside in every year's budget a reasonable amount for the necessary travel so that the administrator and some of the department heads can keep up in their respective fields. Part of this money may properly be used to pay the necessary expenses of trustees who attend significant hospital meetings.

Intern Appointments

ALTHOUGH a committee of the American Hospital Association has recommended that all intern appointments be made on November 15 so as to minimize as much as possible the disruption to both the hospital's and the intern's routine that is involved in having a wide variety of dates for appointment, some hospitals continue to "jump the gun."

No agency is now empowered to enforce the gentleman's agreement and such policing of the hospital field

would probably be unwise. But, certainly, the administrator who "fudges" in this manner can hardly expect to win and retain the confidence of his fellow administrators. It is a sorry situation if, in such a simple matter as this, the hospitals of the United States cannot abide by a general decision which in the long run will redound to the good of hospitals, medical schools and interns.

Employing Former Patients

IN THE January issue we published a thought-provoking article by two authorities in the field of pulmonary disease on the employment of former tuberculous patients in hospitals and sanatoriums. Because of the relatively small number of employees involved, the authors draw no final conclusions, but they have given us a scientific study of a personnel problem that has wide public health implications.

There was a time when hospitals were expected to employ the handicapped because, for some mysterious reason, it was believed that the hospital was a natural place for them. During the course of the years the pendulum swung to the opposite extreme and hospitals proclaimed their need for healthy employees in order to give the best possible care to the sick. The argument ran a fortiori: if industry, which deals with mechanical production, asks for and obtains healthy personnel then surely hospitals, which deal with the sick, are entitled to the best that the labor market can afford. If any socially minded hospital administrator was tempted to let down the bars on occasions, he was discouraged from doing so by the extension of the workmen's compensation laws, which held the hospital responsible for the care of an employee who came down with tuberculosis at any time during the course of his employment.

This article presents a convincing argument that we would do well to follow up at this time when, for good reasons, we are already considering the admission of tuberculous patients to general wards. It deals with a group of 83 men and women who have had clinically active tuberculosis and who have been employed in a

tuberculosis sanatorium over a period of twenty-six years. Only eleven days of work out of each year were lost because of treatment for reactivations. This, as the authors properly point out, is more than offset by the fact that the average length of employment of these former patients is about double that of other employees. They maintain further that the type of service rendered by these former patients compares favorably with the work done by other employees and conclude by saying that these patients have not been responsible for a single compensation award. The risk can doubtless be reduced further by a stricter selection of patients and the authors state that it is much more important to consider the apparent stability of lesions over sufficient periods of time than their mere anatomical extent.

Administrators of hospitals would do well to take this plea under advisement. The subject deserves to be explored further because of its social possibilities. "If hospitals, and in particular tuberculosis hospitals, do not provide employment for these former patients, it can hardly be expected that anybody else will." The hospital administrator who is socially minded should be willing to adopt this statement at its face value.

Master Plan for Hospital Care

THE Hospital Council of Greater New York has announced in its annual report that it is starting work on the development of a master plan for hospital care of the sick in New York City. This project is designed to form a part of the general master plan of the city and, it is expected, will go forward steadily now that John E. Ransom has been appointed executive secretary of the council.

Such a project is an important move toward more effective cooperation among hospitals and toward better coordination of hospital effort. Other communities will follow the New York experience with interest and may, indeed, wish to emulate it.

How to Train Residents

MANY hospital administrators and some physicians have wondered whether the rising standards for the education of residents would result in reducing the supply to a point where there would be too few specialists to meet the needs of the community. In its study of this problem, the Commission on Graduate Medical Education analyzed the figures carefully and came to the conclusion that there was no real danger here. In fact, the commission found that the number of residencies of three years or longer was increasing so fast that there was probably as great a danger of too many specialists as too few.

Nevertheless, the recommendations of the commission and the requirements of the Advisory Board for Medical Specialties have seemed to certain people to constitute difficult hurdles. At its recent meeting in Chicago, the American College of Surgeons gave what

is, perhaps, the best possible answer to these objections. It issued a manual of graduate training in surgery which carried detailed descriptions of the 200 different plans for providing such training that have been approved by the college. Any hospital that has sufficient clinical material and the necessary facilities to offer graduate training in surgery or in the other specialties will find in one or another of these plans the answer to nearly every problem that may arise.

Many of the teaching programs that have been approved are, of course, offered by hospitals controlled by or affiliated with medical schools. But there are other approved courses that have, as yet, no medical school affiliation for their graduate training. Some of the approved courses are in hospitals of less than 200 beds and a few in specialty hospitals of less than 100 beds.

The American College of Surgeons is to be congratulated upon the work it is doing in the field of graduate education and particularly upon the publication of this manual, which will be heartening and stimulating to every hospital that is qualified to undertake residency training.

Labor Law in California

RECENTLY a California hospital sent a questionnaire to its employees to determine certain significant facts about their experience and qualifications. Among other questions was one on union affiliation. The employee was also asked to sign a statement agreeing to do his work faithfully, to conform to all rules and to accept dismissal whenever notified by the superintendent. Then appeared this sentence: "The hospital reserves the right to deduct for absence from whatever cause and for any damage done to property while in its employment."

The administrator of the hospital was summoned to appear before the California labor commissioner to answer certain questions about the questionnaire. First, the commissioner stated that firms subject to the Wagner Labor Relations Act have no legal right to ask an employee about his labor affiliations and suggested that hospitals ought not to do this.

He also instructed the hospital to omit the phrase "from whatever cause" in the sentence about deductions since this would prevent an employee who worked overtime from obtaining pay if he later were absent an equal amount of time. The authorization for deduction for breakage also had to be omitted since the laws of California require the employer to pay the stipulated wage. If damage is done to hospital property, the only recourse is through the civil courts.

These may appear to be hairsplitting matters but careful observance of the labor laws of the state will frequently avoid unnecessary difficulties. Each state hospital association might well compile and distribute to its members the labor laws of its state so far as these are applicable to hospitals. Such forethought would save many headaches.

Collection Letters That Pull

HELEN M. YERGER

Assistant Administrator
Park Avenue Hospital, Rochester, N. Y.

THE "balance due" has been and still is a subject for serious consideration here at Park Avenue Hospital, Rochester, N. Y. During the early years of this institution's growth (it was organized in 1921) it enjoyed the postwar activity and not until after the depressing year of 1929 did the accounts receivable begin to increase to an extent that caused us deep concern. Various collection methods were used; some produced results, others did not. In October 1939 we made an analysis of our accounts.

The analysis revealed that no patient paid an old hospital bill with any degree of pleasure. Sickness and loss of time had forced deprivations upon these people and in their struggle to maintain a financial equilibrium a natural resentment was created against the hospital.

It was the opinion of some of us that, if the people had a better understanding of our problems, in the course of time their attitude would change. This feeling of resentment might become one of gratitude and appreciation, with a resulting increase in the percentage of collections.

At the time the first letter was written there had been agitation about some new pieces of equipment. The doctors had been talking about them and, in so doing, had transferred the thought to many of their patients. The patients, in turn, told the story to the nurses. It occurred to us that inasmuch as this wave of equipment conversation had gone thus far it might be well to incorporate the thought in a collection letter. Hence, the appeal in the first letter.

As the patient feels closer to her nurse than to any other individual in the hospital, the story of a nurse's hours on duty and her contribution to the patient was set forth in the second letter. The incident related was true—an experience of one of our former patients who was expected to die but who decided she

Oct. 1, 1939

Mrs. John Smith
Rochester, N. Y.
Dear Mrs. Smith:

Most people have a perfect horror of the thought of having to be a patient in a hospital. Yet, in a great number of cases after a patient has experienced a hospital stay, he is forever grateful for the service and results.

The secret behind this change of mind is the concerted effort hospitals are exerting in making a patient more comfortable and in creating a friendly atmosphere for the patient to enjoy. This means a larger expenditure of earnings and an increased number of trained employees. Reduced to simple terms, this increased effort means "spending money."

This is just what we should like to do. But, before we can spend, we must collect what we have earned. There are many replacements needed as well as improvements to be added for our patients' future comfort, but until we receive your check for....., owing since....., we shall be hindered in our progress.

We believe you appreciate that the hospital is an integral part of the community and the responsibility the hospital has to its patients. Won't you, then, help us in our great work by sending your check for..... so that we may maintain at all times a nursing service of which you can be proud?

Very truly yours,

Letter No. 1

Nov. 1, 1939

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

Just the other day one of our former patients returned to demonstrate how well she was feeling. This patient had been very seriously ill for more than three months. She was so pleased to recover that the first thing she did was to come back to the hospital and thank her nurses.

This patient claimed that her recovery was due, in a large degree, to the splendid nursing care she received. She said that many times she felt depressed and uncomfortable but that the nurses quickly responded with patience, kind words and a real understanding of her case.

This consideration is being rendered to all of our patients every day and every week in the year. Yet, while the majority of all workers are on a forty hour per week schedule, these nurses are continuing to work on a forty-eight hour basis. This means, too, that while you are enjoying your week end or Sunday, these kind administering souls may enjoy only one or two Sundays free in the course of a year. If any group of working individuals needed to recharge their exhausted spirits, it is these nurses who constantly give of themselves to others.

This problem of reducing the working hours is not solely a hospital problem. It ties in very definitely with you—you and all the other patients who have received care and assistance and go forth with unpaid balances.

We know that you are a humanitarian at heart and that you will help us in solving this difficulty. Your check for..... or part of it will greatly assist us to render a greater service to those who suffer.

Yours very truly,

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

You may be interested to learn the story of one of our former patients. He was a young man in the twenties, father of two babies. He was employed steadily in one of the large industrial plants and earned approximately \$35 per week.

He became ill; hospitalization was forced upon him. He lacked sufficient funds to pay the account but promised small payments each week. Several weeks passed and no payment was received. A letter was sent to him, asking him to come into the office to talk over this situation. This he did.

After carefully analyzing his expenditures and comparing them with his earnings, it was discovered that he had obligated himself for more than he earned in a month. In other words, he had signed contracts which totaled \$40 per month, when after the real necessities of living were paid there remained only \$20 per month.

When these facts were made known, it was suggested to him to apply for a loan to cover his indebtedness. This enabled him to repay the bank in fifteen months on a \$15 a month plan, thereby giving him financial relief and a few dollars left over.

Perhaps, the reason your account of..... remains unpaid is due to the fact that you have had other debts which have used your spare cash. Many of our patients, both present and past, have been using the Central Trust Small Loan Service and are finding it most satisfactory.

Why not come into the office and give us an opportunity to analyze your situation. It may be possible that a small loan will enable you not only to clear this account but to clear others that you might have.

May we hear from you?

Very truly yours,

Letter No. 3

Letter No. 4

Dec. 10, 1939

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

"Institutions are cold blooded. Any way you take them they are JUST INSTITUTIONS."

This statement was directed to us by a very good friend. It stayed with us and, after thinking it over for several days, we decided that if you had that impression then our efforts have been in vain.

We, all of us here at Park Avenue, honestly try to be of service to patients and their families and friends. When sickness does manifest itself, we appreciate, as well as you, that it is anything but voluntary. On the other hand, hospitals are vital to the health of the community. They need to be kept in a state of perfection at all times. Just as you have found it difficult to meet the balance on your account so, too, hospital executives find themselves exerting ever so much more effort to "make both ends meet."

But to blast the attack of "cold bloodedness," we are saying to you now, forget your balance due for this month—have all the fun and cheer and happiness that you can. We know that you will remit when you are able to do so.

Let this Christmas Season be an outstandingly happy one for you. And, while you are reveling in the best wishes of your many friends, please accept ours for a Happy Christmas Season.

Very truly yours,

Letter to Employers

May 28, 1940

Rochester Gas & Electric Corporation
Rochester, N. Y.
Gentlemen:

Because the majority of the employers in Rochester share and sympathize with the responsibilities imposed on hospital administrators, we are appealing to you in regard to your employe, He was admitted on and discharged

There remains a balance due on his account of Statements and letters have been sent to him and for some reason or other he fails to respond. Is it expecting too much to ask you to appeal to Mr.? You, as his employer, would be able to exhort him to fulfill his obligation to this institution.

Because this institution is maintained solely on the funds received from patients, without the aid of endowments or funds, we stress every available means to collect on an account. If Mr. fails to act upon your advice, we feel that our last recourse would be to give his account to our attorneys. This we hesitate to do because it not only causes embarrassment but increases the amount to be collected, which in most cases increases the burden.

If there is anything you can do to facilitate the payments on this account, you may be assured that we shall be duly grateful to you for your cooperation.

Yours very truly,

Letter No. 7

June 12, 1940

Mrs. John Brown
Rochester, N. Y.
Dear Mrs. Brown:

Last week was Commencement Week in all of the Rochester hospitals. The graduates were feted and entertained in many circles.

Breakfast-on-the-lawn at the Park Avenue Hospital is a yearly event and is attended by the whole personnel, board members, training school board and committee members. It is one of the loveliest of functions. Everyone assembles on the lawn for breakfast. Heads of various committees and presidents of the board and staff relay glad tidings and best wishes to the graduates.

Gifts are presented to the graduates from their underclassmates and, finally, the graduates present to the hospital a gift or token of their appreciation. This year's gift was in the form of a cash fund, which is to be enlarged upon by other classes coming up. It was created for the purpose of purchasing a movie projector so that, in the education of our nurses, various educational films may be used to demonstrate more clearly the subject in question.

As this presentation was taking place, it occurred to us that it was a shame that the hospital was not in a position to purchase a machine outright for the nurses. Upon further study of our "accounts receivable" it was revealed that, if our patients would, in turn, pay us for the services rendered, the hospital would be in a fair position to give this educational development to the nurses who, in turn, give it in care and comfort to you, the patient.

This is only one of our many wants and needs, so we are again appealing to you to send us the amount owing on your bill of April, which is

We feel definitely certain that you want to cooperate with us in our humanitarian enterprise.

Yours very truly,

Letter No. 5

Feb. 1, 1940

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

It is customary for hospital officials to set up a budget for their respective institutions, a budget that will be a guide for future buying and spending. Each month as the report is tallied, it is also compared with the corresponding figures in the budget column. In this way the hospital administrator is able to keep supplies at a safe level, equipment up to date and ample drugs and narcotics, which are needed for all cases, on hand. In other words, the objective is to keep the institution supplied and equipped adequately for patients' needs and demands.

It occurred to us, in going over your account of that perhaps, if you were to set up a budget for your needs, as well as your anticipated earnings, you would then be in a position to tell us when we may expect settlement of your account. The amount is not so large but that with a little concentrated effort and good will it could be reduced and settled.

Will you, therefore, please try and cooperate with us, either by sending us the amount in full or by telling us just when and how you expect to clear your account?

Yours very truly,

Letter No. 6

April 1, 1940

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

Your interest is, no doubt, being directed to the flood area south of Rochester. You probably saw the pictures in the paper and visualize from them the devastating effect this will have not only on the land and property but on the people as well.

Hundreds of home owners have been forced to leave their homes. Schoolhouses are serving as a sheltering place for many. Health officers not only of towns but of the county and state are taking every precaution to prevent disease from spreading. With a flood condition such as this one, epidemics occur most readily and it takes a well-organized medical preventive program to avoid one of any kind.

Something that you would not realize is that vacant beds are at a premium in the six major hospitals in Rochester. There was a time only yesterday when there was not a vacant bed to be obtained. To a hospital administrator a natural busy situation is a huge responsibility, to say nothing of the burden if an epidemic were to spread. The six major hospitals in Rochester would be called upon to act if the emergency necessitated.

Even though this institution operates independently of the Community Chest, it would, in times of stress and emergency, serve with the other hospitals. To do an effective service, however, an administrator needs cooperation and help not only from the doctors and nurses but from those whose accounts are still unpaid.

Won't you help us by remitting in full or, if this is inconvenient, tell us when you will remit? Your balance is Yours very truly,

Letter No. 8

July 17, 1940

Mr. John Doe
Rochester, N. Y.
Dear Mr. Doe:

If you read Sunday's "Democrat," you probably noticed an article relating the efforts the United States government is making in buying reserve supplies of narcotics. Quinine was mentioned particularly as being one drug which the United States would be forced to import and which, if the supply were limited, might cause untold suffering in the event trade relations were to be suspended in the East.

Supplementing this article, emphasis was also given at the recent New York State hospital convention for administrators to increase their inventories on these vital items which are imported. Quinine is only one of the many drugs necessary in alleviating human suffering. There are a great many more.

For an administrator to order for the future means that he must have adequate cash surplus. In the majority of institutions serving the sick, this condition is a rarity because the patient is always given care regardless of circumstances.

Here at Park Avenue Hospital, without the aid of endowment or special funds, a great deal of effort is spent in rendering a service to those who need it. As a former patient and one who is familiar with this institution, we are sure you will want Park Avenue to make just as fine a contribution in the event of a future emergency as other institutions. To do so, we need your assistance, your loyalty. You can help us right now to procure the necessary supplies for the future by sending us the balance due on your account, which is

We are sure we can count on your support. Thank you.
Yours very truly,

would rather live. This letter had an exceptional response. Many letters were received with partial payments enclosed; a number of patients paid in full, and several wrote to tell us when we might expect to receive a payment.

The fact that the majority of people are honest, or mean to be, was the basis of the next letter. So many people in the wage scale of \$35 per week or under overestimate the stretch of their salary. What with supporting a family of two or three and buying an automobile, a refrigerator and a radio on time, there isn't anything left for the hospital or doctor when sickness does manifest itself. It was our feeling that if these people could be helped to direct and guide their financial status more wisely, they would be able to pay the hospital.

Several of the banks in Rochester have opened small loan departments, lending amounts up to \$300 without a second signature or collateral. The drawee, however, must have a job that pays a wage that will justify the loan, as well as a good credit rating.

Arrangements were made with the Central Trust Bank to investigate such applications as we might send into them. This plan proved most successful because, when the application was sent into the bank, the investigation was made immediately and the hospital was informed whether the loan would be granted or not. In cases in which the loan was granted the hospital was paid in full, thus eliminating the necessity of carrying an open account for a period of months.

Financial Counsel Given

There was a large response to the third letter. We were busy many nights meeting various individuals and analyzing their financial difficulties. A number of people who responded resented the idea of borrowing from the bank. This presented a splendid opportunity to explain to them the reasons why it was necessary for the hospital to have the use of the money that was owing to it and to which it was entitled.

The fourth letter was the most outstanding. It was prompted, as it discloses, by a general discussion about hospitals. The friend who made the statement quoted had been a patient in several institutions and,

when she asserted that "institutions are cold blooded," it left an indelible imprint on our minds for her opinion commanded respect.

After wrestling with this problem for more than a week, it was decided to incorporate in a letter the feeling of Christmas, since it was the Christmas season, and to tell the patients to forget their balance due for this month. The effect of this letter was more than we ever expected. The cash collected in January 1940 was the largest amount of any month in the history of the hospital. Between taking care of all of these accounts and being so overwhelmingly pleased with the success of the December letter, no letter was sent in January.

February Returns Are Weak

In February, because the first of the year always presents budgets for all types of businesses, this topic was used to bring home to the patients the fact that the hospital must be administered as a business. This letter pulled the fewest responses. Perhaps the response in January was so exceptional that the results received from this letter seemed meager. However, we still feel that if the patients can be made to realize that cash is needed in the running of an institution then the letter is not without merit.

South of Rochester are lowlands bordering the Genesee River. When the snowfall and ice have been excessively heavy, serious damage is caused by floods. Last year the area damaged was much larger than in recent years. Hundreds of people were forced to vacate their homes. At the time all of the beds in the major hospitals were filled. The Rochester Hospital Service Corporation was constantly calling on the telephone to obtain beds for its subscribers. If an epidemic had followed it would have been disastrous. This situation inspired the sixth letter.

The city of Rochester has a community chest. The chest helps to support four of the major hospitals, but the Park Avenue Hospital is not one of the four. Our institution is owned and controlled by a group of doctors and operates on a nonprofit basis. It functions, however, in the Rochester Hospital Council along with the other hospitals of the city. Because so many of the Rochester employers are donors to the community chest,

they are familiar with the work being done in the various hospitals.

A list of accounts was made of patients employed by Rochester concerns and a letter was sent to their employers. Favorable responses were received from all but one of the organizations. Some of the employers even went so far as to call after a period of a month or so to check on the account. We derived a great deal of real satisfaction from this letter.

Each year the hospitals in this city unite for community graduation exercises. Newspaper and radio publicity is given to these exercises and the people of this city take a great deal of pride in the event. It is an inspiring sight. This community interest in the nurses' graduation inspired letter No. 7. Because of the appeal in the letter several persons offered their assistance in selling tickets to raise money for the fund and others offered donations.

The war situation in Europe and a newspaper article prompted letter No. 8. The amount collected was average.

Collections Now Average 99.6%

An analysis recently made of our accounts receivable revealed that since these collection letters have been used we are collecting 99.6 per cent of our accounts. The amount collected on the suspense accounts has shown an increase of 41 per cent over the preceding year.

Not only have the results been more than satisfactory, but increased interest in the campaign has been demonstrated among the personnel. Each month an amount is set to be collected and the effort made by employes in urging the patient to send in his payment on a given date is surprising. This interest on the part of the employes, we feel, is worth while because it makes them much more conscious of the affairs of the hospital and enhances their interest in it. Each month recently we have sent to those who are directly concerned with the accounts the cost per patient day for the preceding month.

It is our intention to continue to use this type of collection letter. Each month we hope to vary the appeal and choose subjects that will be of interest and that will increase the public's appreciation of the work that is being done in the hospital.

Glens Falls Grows

MODERNIZATION pays. A hospital that in 1937 averaged 83 patients at a per capita cost of \$5.02, in 1940 averaged 121 patients at a per capita cost of \$4.87. A miracle? No, merely the replacement of an old, overcrowded building with a modern, efficiently planned medical center!

The year is 1937 and we are visiting Glens Falls, N. Y., for the first time. A town of some 18,000, Glens Falls hasn't changed materially through the years, being quite content with its modest location on a spur railroad line. Its hospital, incorporated in 1897, had, after several expansion programs, attained a bed capacity of 95 by 1910.

At the time of this first visit to Glens Falls, however, it is plain to be seen that the building is inadequate. Many people drawn from a 25 mile radius and representing an aggregate of 25,000 are taking advantage of hospital insurance plans with the result that the building is operating at 100 per cent capacity.

We find a three story brick structure bearing up bravely, but not altogether efficiently, under the burden; hence, the patient per capita cost of \$5.02. Let's step in and glance about briefly. Offices and wards are on the first floor. Just how Rose Q. Strait, superintendent, manages to carry on in an office which is only large enough for her but which accommodates business and admitting departments is difficult to realize.

Beds are found in every available corner, the solarium having long since been diverted from its original function. On the second floor are private and semiprivate rooms, while on the third floor are the one major operating room and the delivery room, minor surgery being done in the anesthesia room. A miscellaneous assortment of cupboards and closets is scattered here and there and in the midst is the autopsy room.

It became evident to the trustees that something must be done. The simplest way to solve the problem was to start all over again and to erect a modern community medical center to serve present and future needs as accurately as they could be foreseen. But Glens Falls is not a

wealthy town and the \$1,500,000 that would be necessary is a sizable sum anywhere. After close study of the situation, it was finally decided that modernization was the solution.

turned about. What we remembered as the front is now the side, with a brand new imposing entrance on a spacious landscaped area. To the right of the front entrance a new



Left: Glens Falls Hospital before its "face lifting" operation, and above, after the rejuvenation process was completed. The new wing increased the bed capacity to 150 and, even so, the hospital's occupancy is high.

Anyone who has visited Glens Falls once wants to return. Therefore, it is with keen anticipation that we approach the attractive community for the second time. Over the bridge we drive and up the hill to the business center. Three years have brought few changes. Everything looks precisely as we remembered it until we strike off to the left and approach the hospital.

Here is rejuvenation indeed! The face of the old brick building has been not only lifted but completely

wing has been added forming a long, four story structure.

It so happens that the new wing, too, is planned for further enlargement, for, as astonishing as it seems, no sooner are we inside Miss Strait's present commodious office than we are told that in 1939, based on a bed capacity of 150, the hospital was running an occupancy of 82 per cent. Figures for July of 1940 showed an occupancy of 94 per cent; August and September, 93 per cent, and Miss Strait and her board are beginning

by Giving Service

RAYMOND P. SLOAN

to wonder if the time will ever come when the solarium can be used as such.

Suppose we inspect the old wing first and see what has happened. It is surprising how completely the exterior has been molded into the modern architectural pattern. Gone are the old terra cotta trim and the limestone sills, key blocks, coping, base and belt course that ran around the third story windows. In their place bricks have been substituted.

Gone, too, is the old main entrance, that entire side of the building now being occupied by the Thomas H. Foulds Memorial Laboratory, the gift of Mrs. Foulds, of which Dr. Maurice Maslon is director. Modest about most things, Glens Falls proudly boasts of this laboratory, which is one of the finest in that section; its equipment alone cost \$30,000. Spacious windows on all sides add to the impressiveness of the layout.

Adjoining the laboratory are the x-ray department, the dental clinic, physical therapy room and the business department. On the same floor in the new wing are the children's department and the medical wards.

The second floor of the old wing has been made over into interns' accommodations and isolation rooms, while the rest of the floor, both new and old, is for private and semiprivate surgical cases. In the center of the building, above the main entrance, is a large solarium for ward patients, the private patients having their solarium at the end of the floor. At the other side of the elevators is located the visitors' waiting room. The same arrangement applies to the third floor, which is devoted to maternity work.

The fourth story houses the operating suite. It does not run the entire length of the building but is centered to afford a spacious roof deck at the southern end for convalescent patients.

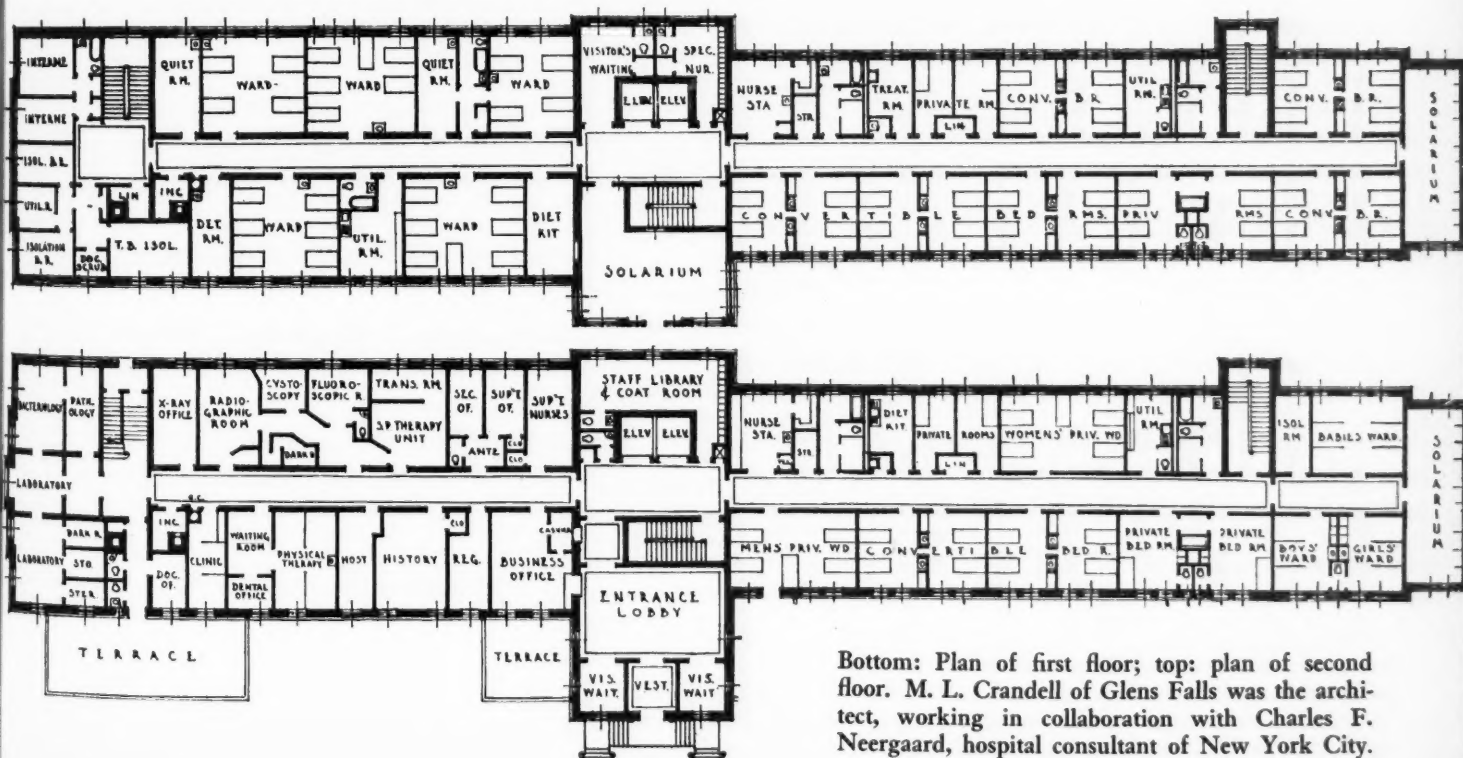
There are two main operating rooms with a scrubup station between, a sterilizing room, utility room, an anesthesia room and another, smaller operating room. In the space over the ward solarium on the floor beneath is the nurses' workroom, while doctors' lockers occupy the position alongside the elevators that corresponds to the visitors' lounge below. The rest of the floor

is given over to living accommodations for the superintendent and director of nurses and to a large assembly room, which is attractively furnished for meetings and also affords recreational facilities for the nurses.

Finally, a trip to the basement. Here we find a new kitchen as well as nurses', employees' and staff dining rooms. The basement in the old wing where the kitchen was formerly located is now a modern laundry and ironing room. Space is provided also for lockers for the personnel and for an emergency room. The original boiler room was kept with one boiler added. Beneath a brick paved terrace to the left of the main entrance a modern autopsy room and a carpentry shop were installed.

The capacity of Glens Falls Hospital today is listed at 150 beds but this can be increased to 190 by converting a number of the private rooms into semiprivate accommodations and by placing beds in the solarium. The cost of the modernization program, including plumbing, heating and electric work, was approximately \$500,000.

Despite this expansion program, with higher occupancy, greater over-



Bottom: Plan of first floor; top: plan of second floor. M. L. Crandell of Glens Falls was the architect, working in collaboration with Charles F. Neergaard, hospital consultant of New York City.



Above: The attractive assembly room on the fourth floor which affords recreation facilities for the nurses. **Right:** A corner of the nurses' dining room located on the ground floor.



head and extended services, per capita cost has dropped steadily. The last year in which the old building was used, that is, 1937, per capita cost was \$5.02. In the following year, which constituted an in-between period, this figure jumped to \$5.59, owing, as Miss Strait explains, to the fact that laundry had to be sent out. Look at 1939, however, when the new building was occupied, and note the figure of \$5.24. The first six months of 1940 showed a further drop to \$4.87 and this drop continued throughout the fall to \$4.84 in August and \$4.56 in September.

The answer is modern efficiency, of course. The new kitchen, for example, has contributed appreciably to the reduction in costs. Expansion of the business offices, including a credit department that has been completely reorganized, likewise has helped to make a better financial showing. Incidentally, the hospital operates on a budget of approximately \$18,817 a month.

No sooner was the hospital in its new building than Miss Strait and her associates, and here the term "associates" includes board members, started to study first one department and then another to see what could be done to eliminate waste and to organize on a sound basis. Receipts from earnings had decreased owing to lack of business office personnel, for example. What could be done about it? It was not long before a committee of board members was appointed to help solve the problem. Here is a board that appoints committees when an emergency exists and as promptly disbands them when they are no longer needed.

It was decided that a personnel of four was necessary to carry on the

credit department successfully—a director and three assistants. Under the present plan, it is customary for the patient to pay one week in advance. If no money is forthcoming, the admitting clerk refers the patient to the credit department where the director takes the case under advisement, talks to the patient or members of the family, makes note of the social history and, if necessary, surveys the family budget. The payment may be no more than \$2 weekly but the aim is to make it a paying case.

Once admitted, the patient becomes the director's responsibility. All business negotiations are made with the family, however, leaving the patient out of the picture as much as possible. Sometimes a small printed card with the name of the nearest relative filled in is left with the patient. "Will you be good enough to stop in at the business office at a certain stipulated time?" If any explanation is necessary, the patient is told that this is merely business routine. Should the financial obligation remain unfilled, the director tries to make some equitable arrangement.

While the director is thus engaged, the other girls in the department are occupied with a thorough follow-up system. A tickler file keeps before



them the date set for the payment. If no word has been received when that date arrives, the patient, or whoever is responsible for the account, receives a telephone call or letter, following which another date is set and placed in the tickler file. Five or six such contacts are made before any action is taken.

Now for the most interesting part of the experiment. The hospital employs a young woman who spends all her time traveling about the community collecting delinquent accounts, explaining the hospital to the

public and building good will. Although she has been working only a few months, the results have been gratifying. In August, for example, collections amounted to \$59.90 and in September, \$221.30. More important than the actual money received are the missionary work she does and her interpretation of hospital service.

Much of the success of such a program lies in the cooperation extended by the doctors. Good teamwork has made possible surprising results in the comparatively short time that the new system has been in effect and today all calls for admittance are referred by the doctors to the credit department.

Some years ago, Glens Falls gave up its nursing school and has never had any regrets. The one aim in reaching this decision was to provide the best possible nursing service. Higher nursing standards requiring the absence of the girls for long

periods for their affiliation made the problem of continuing the right kind of school a serious one. You can operate more cheaply with an all graduate staff was the conclusion, that is, if you are going to give the students what they should have. So Glens Falls graduated its last class in 1933.

A staff of 56 graduates now does the work with the assistance of practical nurses from the Albany Training School for Practical Nurses, Albany, N. Y., and from the Child's Hospital of the same city. The complete course of instruction is from twelve to eighteen months, four of which are spent in Glens Falls Hospital. These students receive classroom instruction, starting with washing the patient's face and, finally, giving a complete bath. They are taught the care of chronic disease, convalescent and diabetic patients and assist generally in everything that does not require aseptic technic.

Miss Strait believes in getting both administrative heads and employees together at regular intervals to discuss mutual problems. Employee groups meet once a week by departments, that is, nursing, dietary and maintenance. The last Friday of each month the employees of all departments get together. Once a month, too, there is a general meeting of the administrative group.

These meetings have proved helpful in maintaining morale throughout the entire organization.

Any comment on the growth of Glens Falls Hospital would be incomplete without some mention of those men who have grown up with it, who have, in fact, always kept a few steps ahead of it. There are 15 trustees who have played an important part in the hospital's affairs during the years. This they have been able to do because they have been kept informed.

When it became evident that collections were not what they should be, the board was advised that some expense would be involved in setting up an efficient credit department. The members agreed and formed a committee to help organize the work.

The hospital is fortunate, too, in having an active guild, comprising some 160 members, women who are constantly seeking ways to raise money for its many needs. They pay the salary of the medical social worker and a major portion of the dietitian's salary; in addition, they pledged \$15,000 toward the new building. So seriously do they accept their responsibility that members are actually fined if they do not attend meetings once a month.

Among their many functions, members take turns spending some time at the hospital each month with Miss Strait, going through the building with her and checking the complaint forms which patients are requested to fill in when they leave the hospital. This is particularly helpful in acquainting them with the attitude of patients so that should they hear of any criticism, of food being served cold, for example, they are in a position to protest with authority on the basis that they see all patients' comments and criticisms; rarely has there been a complaint about cold food.

Thus, the hospital story is brought home to the residents of Glens Falls. That it may survive from one generation to the next, high school boys and girls are likewise included. In groups of 10 they come to the hospital to be introduced to modern medical practice and are told of the many opportunities for young people in hospitals today.

Glens Falls Hospital has grown through encouraging others to grow.

Left: Glens Falls is proud of the impressive new Thomas H. Foulds Memorial Laboratory, which is one of the finest in that section.



Right: Solariums for private patients are located at the east end of the building. Flowered draperies and leather upholstered lounge chairs make them gay and cheerful.



X-Ray Work in Small Hospitals

DAVID M. CALDWELL, M.D.

Surgeon-in-Chief, Manchester Memorial Hospital, Manchester, Conn.

EVERY approved hospital should have an x-ray department. The size and equipment of this department will depend on: (1) the type of hospital; (2) its proximity to larger institutions, and (3) the number of examinations made annually.

If the hospital is located close to larger institutions where all facilities are available, it will be found best to refer all x-ray and radiation therapy cases to the larger institution because deep x-ray therapy equipment, or radium, is too expensive a proposition for the average small institution and, also, because this form of treatment requires supervision by an expert radiologist, who is not always available in the small institution.

Should Give 24 Hour Service

The hospital should be prepared to render service in taking and interpreting satisfactory films at any hour of the day or night. It is not possible for the average small hospital to have a qualified radiologist present at all times, however, and in such instances it is advisable to have on the staff a physician who has taken special work in the interpretation of x-ray films and who is qualified to give an immediate interpretation, always subject to the review of the radiologist at the earliest possible moment. All films that are difficult of interpretation, such as lungs, gastro-intestinal series, kidneys and skulls, should wait for the radiologist's reading.

The minimum equipment for such a service should include a stationary unit with stereoscopic film changer; a fluoroscope, which should be used only by the radiologist; a satisfactory viewing box, and adequate filing cabinets and index cards. A portable unit, while not absolutely essential, is highly desirable, particularly in the small hospital to which many fracture cases are admitted. The equipment, of course, will vary according to the type and activity of the hospital. Furthermore, machines are being developed so rapidly that it is impossible to be specific regard-

ing the transformer, tables and similar equipment. In purchasing new equipment the administration must be guided largely by the radiologist in charge of the department.

All films should be marked with erasable markings so that no mistakes can be made. Duplicate reports should be made, one to be attached to the patient's record and one to be filed in the department. For this purpose a common practice is to paste the findings on the individual envelope containing the films of each examination.

An important feature in the x-ray department is the maintenance of adequate technical service. The radiologist must be assisted by one or more qualified x-ray technicians, depending on the number of x-ray examinations and treatments given. In the small hospital where the number of examinations are limited the duties of the x-ray and laboratory technicians may be combined.

There are definite standards for training technicians and only those who are registered should be employed. Qualifications for training and registering technicians in roentgenography have been adopted by the American Board of Radiological Technicians and approved by the Radiological Society of North America. The essential qualification is that the technician must be competent to make films of good quality for, under no circumstances, should the technician attempt to render an x-ray diagnosis.

The department should be under the direct supervision of a physician radiologist who shall be responsible for all examinations and treatments, for the work of all professional assistants and for the efficient maintenance of the department. The radiologist must be a graduate of an approved medical school and licensed to practice in the state in which the hospital is located. He should have special training in radiology and, preferably, should be a diplomate of the American Board of Radiology.

The arrangements under which he may conduct the department must of necessity vary according to circumstances. Whenever practicable he should be a specialist, devoting all of his time to the radiology in one or more hospitals. When he has a private practice also, it is mutually advantageous to have him maintain his office in a recognized hospital. The custom of selecting a physician who is in general practice or is practicing in some other specialty is to be sanctioned only in communities that are too small to support a specialist. In such cases his limitations should be frankly recognized and he should confine his interpretations to the simpler cases.

The practice of employing a technician to manage the department and to do the technical work, allowing each physician to interpret his own films, is most unsatisfactory and is mentioned only to be condemned. The radiologist should make arrangements to consult with any and all members of the staff concerning their x-ray problems.

Financing the Department

Financing the x-ray department is always a difficult problem because of the high initial cost of equipment. However, it can be handled in different ways. First, the equipment may be owned by the radiologist who rents space from the hospital and makes his own charges and collections for all examinations and treatments. Second, the equipment may be owned jointly by the hospital and radiologist. This is not a common practice, however, and is not very satisfactory. Third, the equipment may be owned entirely by the hospital which employs the radiologist on a full-time basis with salary, on a part-time basis with salary and percentage or on a straight percentage of the gross receipts. The last practice is the commonest in this country, especially when the radiologist attends two or more small institutions in a community.

Paper presented at American College of Surgeons meeting.

What Do People Think of You?

C. N. ALLEN

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Dartmouth College, Hanover, N. H.

IT IS a common misconception that you have more or less personality just as you have more or less money. Several years ago we had on the staff at Dartmouth College a man who is now recognized by psychologists as an authority on the study of personality. I was amused to overhear a student comment, as he walked out of the lecture room after hearing this professor lecture on the subject to an elementary class in psychology, "Why should *he* lecture on personality; he hasn't any." What he really meant was that this man's personality was displeasing to him.

Personality is not quantitative. You do not have more or less personality but only an adequate or an inadequate personality, a pleasing or an unpleasing personality.

How Others See You

It would seem that you, as hospital administrator, ought to be competent to analyze your own personality in relation to your administrative functions. You must see yourself as others—the members of your staff and the community you serve—see you. You have lived with yourself all your life. But there are difficulties. You have learned to forgive yourself for your shortcomings, even if others do not. One of the strong features of the Dale Carnegie type of system is that it is brutally frank and forces you to be honest with yourself. It takes courage not to kid yourself but I take it for granted that you are interested in a completely honest self-analysis. A good many reasonably accurate standardized inventories of personality have been developed by psychologists, but my function is to develop the idea of self-inventory.

The essence of your problem is to match your assets and liabilities against a job analysis. The following is a summary of what your self-inventory should include.

Presented at American College of Hospital Administrators meeting, Boston, 1940.

1. Physique: Are your height, weight, facial characteristics, complexion and other obvious elements assets or liabilities?

I shall assume that this aspect is obvious and shall insist only that it is possible either to minimize physical shortcomings or to turn them into assets. Hollywood uses contact lenses to eliminate glasses on the stars; President Roosevelt turns his lameness into an asset in his press build-up; experts advise us what clothes to wear to minimize our physical defects.

2. Temperament: Emotionally you are naturally phlegmatic or volatile. Your glands are partly to blame, but only partly.

You can change your temperament, although not as easily as you can change your job. What kind of a disciplinarian are you? Can you give orders gracefully? Do you hold a grudge? These are temperamental traits and they are of greatest importance in the personality complex.

3. Intelligence: What is your innate capacity to learn?

There are adequate tests for measuring intelligence, but they should not be necessary for you. I ask you only to avoid confusing capacity to learn with the degree to which you have put your capacity to effective use. Emotional factors dilute capacity, as any college professor will testify. We see students every year who fall far below their capacity level. Professional men and women, by the same token, let their hearts rule their brains. Here is a place for realism rather than wishful thinking.

These three elements, physique, temperament and intelligence, are part of your heredity, but they are not unchangeable. In fact, you spend your life modifying what you were born with. You cannot grow taller, but you can wear clothes that flatter you. The effect of this one component on the pattern of your personality may be as great as it was and is on those of Napoleon and Hitler.

You can modify and control your temperament. You can make a more nearly maximum use of your intelligence. And as you react to what heredity made you, you develop or learn characteristic ways of doing things. Your personnel soon learns what these ways are and adjusts itself to you accordingly.

I tell my students that it is not what you are half so much as what you do that is important. Others judge your personality on that basis. We mistake diffidence for indifference; aggressiveness for attempts to compensate for an inner feeling of inferiority, and clowning for concealed sadness. Of course, there are simpler personalities in which these traits are just what they seem. Your difficult task is to appraise your own characteristic reaction patterns and to ask yourself why you react this way or that, as well as just how you behave characteristically.

Reaction to Ill Health

The Roosevelt cousins, Teddy and F. D. R., were alike in that they both overreacted to threats to their physique. Teddy refused to be a chronic invalid and expressed it by becoming a virile Rough Rider; F. D. R. more than conquered infantile paralysis. I had a student who became intercollegiate champion on the flying rings and the rope-climb event because he was paralyzed from the waist down. He told me he would never have had any interest in gymnasium work had he not needed to compensate for his handicap.

These people have a temperament that "can take it"; others do not. I met a victim of the depression who had given up so badly that he left society for a private mental hospital. He had lost seven eighths of a two million dollar income and had also lost his nerve; he could not see that he still had a quarter of a million dollars left with which to carry on the fight.

I want to stress this point because your personality affects others by what you characteristically do and appear to be. It is your job to make sure that this side of the equation matches the job analysis. Our columnists are telling us that the world

has gone soft; that the wars bring out latent personality traits that we have allowed to slumber; that many a hen-pecked husband is a tartar in a Sam Browne belt; that bravery appears in the most unexpected places; that Hitler has underrated the personality trait of the British of not knowing when they are licked.

Your staff has made judgments of your personality at the first meetings and will revise those early estimates only if your characteristic ways of doing things change. The community does likewise. Your inventory, therefore, must include an honest appraisal of your physique, your temperament and your intelligence, as well as hypercritical examination of what you are as reflected in your characteristic behavior patterns. If you care for a formal definition of personality to include these elements, here it is.

Personality is the sum total, integrated, of an individual's innate capacities plus his acquired characteristic modes of adjustment to others.

Now, assuming you have made a careful and completely honest self-analysis and have matched it against the requirements of your job, what can you do about the inadequacies revealed? William James' recipe was: "Learn by Doing."

Assume that you have discovered that many of your past mistakes have resulted from your characteristic habit of making snap judgments. This is a temperamental defect and not a question of intellectual capacity. It may be impressive always to give a quick response, but it has been a boomerang to you. You do not want to go to the other extreme and develop a reputation for indecision. One necessary step in making prompt and adequate decisions is to acquire more and better information relative to your problems.

Assuming that you have an ample supply of information with which to meet your problems, the rest is like any other habit-forming situation. Chief of the laws of habit formation is practice. You have de-

cided what weaknesses need attention. Now you decide whether to eliminate the old habits by deliberate extinction—to let them die by disuse while you develop more effective habits in their place—or to turn weaknesses into strengths by developing supplementary reinforcing habits. Your decision must be made in terms of your own particular local requirements. And you must practice the habit you want to make a part of your personality.

It is analogous to becoming proficient in sports. You want to develop good form in golf to lower your score. Analysis has revealed the weaknesses. You go out to the practice tee and practice a new stroke according to instructions. If you are not careful, you will find yourself slipping back into the old errors. Practicing errors is easier and more natural than practicing the harder new habit, but there is only the one way to develop new skills. It is the same in developing personality traits but much harder.

There are measures of personality traits and their degree of development. You can always watch the effect of your behavior upon others. Most of us think we are too busy, but if you have a problem and feel that it is important to improve your technic of meeting that problem there is only one way to develop such an improvement.

Nothing succeeds like success. The rewards for personality improvement are inherent in the satisfaction you feel when you sense a better adjustment to the job. Each successful readjustment makes the next one easier and reaffirms the biblical promise: "To him who hath shall be given, and to him who hath not shall be taken away even that which he seemeth to have." It's a sort of double-or-nothing proposition.

I am aware that my remarks are not new; neither is the problem. I am also aware that I have given no hint of the mystery and glamour of personality put into the package by the numerous quacks and semi-quacks who have a "system" to sell.

Such systems are psychological crutches; we have been discussing how to walk and to run without crutches. Finally, I am human enough to agree with Shakespeare's Portia: "If to do were as easy as to know what were good to do—."

Patient's Dollar, 1940



To each \$1 paid by a patient, there was added 17 cents from endowment income, and 3 cents in gifts from the hospital's friends.

This \$1.20 was spent as follows: 72 cents to get the work done. This included all workers from front door to back door, attic to basement.



Food took 17 cents. Three meals a day for everyone, and special diets for many.

10 cents warmed the buildings in winter, lighted them at night, paid for maintenance and furnished housekeeping supplies.



Drugs and gauze, films and reagents, rubber goods, syringes, instruments, oxygen, ethylene, and like professional material used 11 cents.

Insurance, telephones, stationery, postage, records, printing, and all the things that keep the office going took another 6 cents.



Old man Depreciation on Equipment came along and asked for his share, which was 4 cents, and that makes \$1.20 and is the end of

Evanston Hospital

what happened to the patient's dollar in 1940. Evanston, Ill.

Landscape by Plan Only

GEORGE C. BEBB

Landscape Architect
Department of Public Works, Albany, N. Y.

WHEN one thinks of the landscape development of a state hospital the picture that comes to mind is that of fine old trees on rolling lawns bordering a sweeping entrance drive to the administration building, beyond which, along tree-lined roads, are the beautifully laid out and planted hospital grounds.

It takes years for this picture of a hospital set in a mature landscape to materialize. Some hospitals can carry out their plans only gradually, over a long period of time. From the moment the landscaping is made to follow a well-organized plan, the institution will realize additional benefits in efficiency and beauty.

Landscape architects should cooperate with the architects, engineers and institutional authorities throughout the development of a new hospital or of a new unit for an old hospital. Their work begins with the selection of the site and the preparation of the general layout plan and ends with the completion of the landscape planting.

Let us review the steps to be considered in the landscape development of a new hospital.

The site for the hospital is of prime importance. It should be centrally located to the area it will serve and should be large enough to accommodate all the units necessary for the present and future functioning of the hospital. It should be located on an improved road but not on a main highway, because of the added danger to ambulant patients, and should have access to a railroad or easy trucking facilities, water supply, electric service and a sewage disposal system, if the hospital does not warrant its own disposal system.

The most desirable site is one that is neither too steep nor perfectly flat. An existing average grade of 2 or 3 per cent is most desirable in the building area. The property should be partially wooded although at the building sites it is best that it be fairly open. The soil should be

fertile. There should be a minimum of swamp areas in the construction zones. Fresh water streams and ponds are desirable for developing landscape features.

After the site has been chosen, a complete and accurate topographical survey should be made showing contours at not more than two foot intervals, all existing structures, trees and wooded areas, streams, service lines and any other data on the site that will be of value in preparing the plans and specifications. It is from this survey that all plot, grading and planting plans are developed.

Before the survey is received the building schedule may be set up. The number and kind of patients to

be accommodated at the hospital determine the number and kind of buildings necessary to house and care for them. These buildings will fall into certain definite groups. In general, these groups are administrative; reception and hospital; male patient, able bodied, infirm and disturbed; female patient, able bodied, infirm and disturbed; utility and industrial; farm group; employees and staff.

Each group of buildings and each building within the group bear a definite relation to the other groups and to other buildings. Each of these buildings must be designed and oriented so that it fits the topography and receives the maximum amount



Photographs from McLean Hospital, Waverley, Mass.

A soothing spot on the grounds of McLean Hospital, Waverley, Mass.

of light. These matters and many others must be considered in making the general plan.

For example, let us take a hospital site that faces and slopes down from an improved road. The administrative group is usually placed nearest the road and on the main axis line. Behind this, and still on the axis line, is the reception and hospital group while on either side of this group are the married and single employees' groups. Farther down the slope on either side of the main axis line are the male and female groups with possibly the school, assembly hall and athletic field between them. At the far end of the hospital and at the lowest elevation of any of the buildings is the utility and industrial group.

The farm group is in the area that is to be used for farming. The staff group is located farther down the improved road and is served by a separate entrance road. This group should not be too closely related to the main hospital although it should be within easy access to it as well as to the improved road.

The road layout should be as simple as is consistent with good direct service to the buildings and economical road development.

Unless there are unusual conditions that force a departure from the

rule, the elevation of the road where it passes any building should be lower than the finished grade at the building. This provides surface drainage toward the road and a pleasing relation between the profile of the road and the grades at the building. A building that is set lower than the road is likely to look as if it were set in a hole.

The roads can be constructed of concrete or macadam. The macadam roads are less expensive but require additional maintenance. Permanent dirt, cinder or gravel roads are not recommended.

It is always advisable to provide concrete curbs from 4 to 6 inches wide along each edge of the roads. Curbs do away with drainage ditches, keep traffic on the roads and make a clean-cut division between the roads and the lawns, which thus can be much more easily maintained. In general, walks should follow

the line of the roads and the main routes of pedestrian traffic between buildings. The width of the walks may vary depending upon the amount of traffic although it is felt that a minimum width of 5 feet is advisable.

There are many types of material that can be used for the construction of walks but the two most practical, in regard to initial cost and later maintenance, are concrete and a bituminous top on a stabilized base.

An important facility to consider in developing a hospital is adequate parking for the employees and visitors.

Employees living on the grounds should have adequate parking areas provided for them near their homes, preferably in the rear of their homes or in near-by areas screened from the main hospital.

In small hospitals, employees living off the grounds should be provided

Right: Rolling velvety lawns and beautifully landscaped grounds take a long time to materialize and they must be given unceasing care and attention.



Left: Golf course at McLean Hospital. Facilities for outdoor recreation for patients and employees should be included in the landscaping plans.

with at least one adequate parking area centrally located on the hospital grounds. This area may be used by visitors as well.

In the larger hospitals, owing to the long distances between various parts of the institution, parking strips should be located along the road system to provide adequate employee and visitor parking for each group of buildings. These strips should be from 18 to 20 feet deep to allow for perpendicular parking.

Parallel parking along the normal 20 foot hospital road is not advisable as it causes traffic congestion and many bent fenders. In planning for employes' parking areas, space should be provided for at least a third of the number of employes.

Outdoor recreation areas should be provided for each large building housing able-bodied patients, in addition to a central athletic field for mass games and demonstrations. Also the central athletic field is an important element in the recreation of the employes.

Whenever possible, the rough grading of the grounds should be carried out simultaneously with the construction of the buildings and roads. Whenever the existing ground is to be disturbed the top soil should be stripped and stored in convenient

a small nursery. It can be used later where needed for landscape effects.

The larger trees in the area of grading that will fit into the final landscape development should be protected and saved. No underground service lines should cut the main roots of these trees nor should they be filled around without being properly welled.

Only after the buildings, roads, walks and grading are completed should the actual planting of new trees and shrubs be undertaken. This planting should be based on a complete planting plan that has been prepared in coordination with the other plans for the hospital. This plan should be the result of careful study to obtain a pleasing effect with

the ball; they should then be filled around and packed with top soil.

Most evergreens require an acid soil; peat moss mixed in the soil around the plant helps to hold the moisture and is of great aid in the starting of the evergreens. All plants should be well watered at the time of planting and as often as necessary until they are so well established that they can take care of themselves.

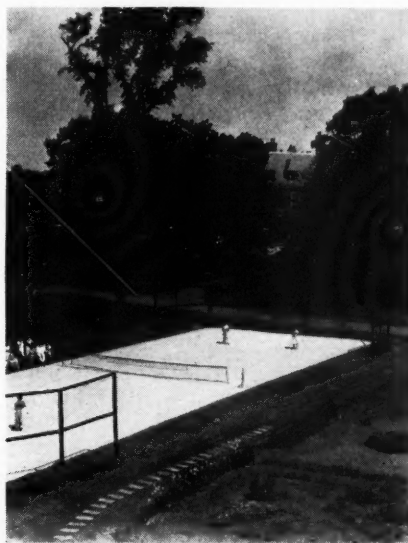
Presentable lawns can be obtained only by using grade A grass seed sown on well-prepared top soil. The seed mixture should be composed of a high percentage of clean grass seed of last year's crop and a small percentage of nurse grass, such as red top or rye grass, which grows fast and protects the permanent grass while tender. This nurse grass is crowded out as the permanent grass develops. Actual recommendations as to the seed mixture to be used depend on local conditions and should be obtained from local authorities.

Preparation of the seed bed can be accomplished in two ways: by the use of from 4 to 6 inches of well-fertilized top soil or by building up the existing soil with cover crops and fertilizing it.

The final step in the landscape development of a state hospital is one that is never completed, that is, the proper maintenance of the trees, shrubs and grounds. Trees, shrubs and grass are living things that require and respond to consideration and care. Every hospital should retain a competent man or force of men as long as it continues to operate to keep the plant material in a good healthy condition and to make any necessary replacements or repairs.

When a hospital development is carried out in accordance with a well-thought-out plan and maintained in accordance with the best engineering and horticultural standards, the resulting benefits in efficiency and beauty far exceed the costs that are involved in carrying out the plan. In fact, there is nothing so expensive in the long run as revisions, adjustments and changes that result from lack of planning and foresight. On the other hand, efficiently planned and carefully planted hospital grounds contribute materially to the efficiency of employes, the well-being of patients and the pleasure of visitors.

Right: A tennis foursome attracts a gallery of interested spectators.



plants that will thrive and will not be too costly to maintain.

In purchasing the plant material it should be specified that each plant be true to name, of normal characteristics, alive, healthy and free from damage.

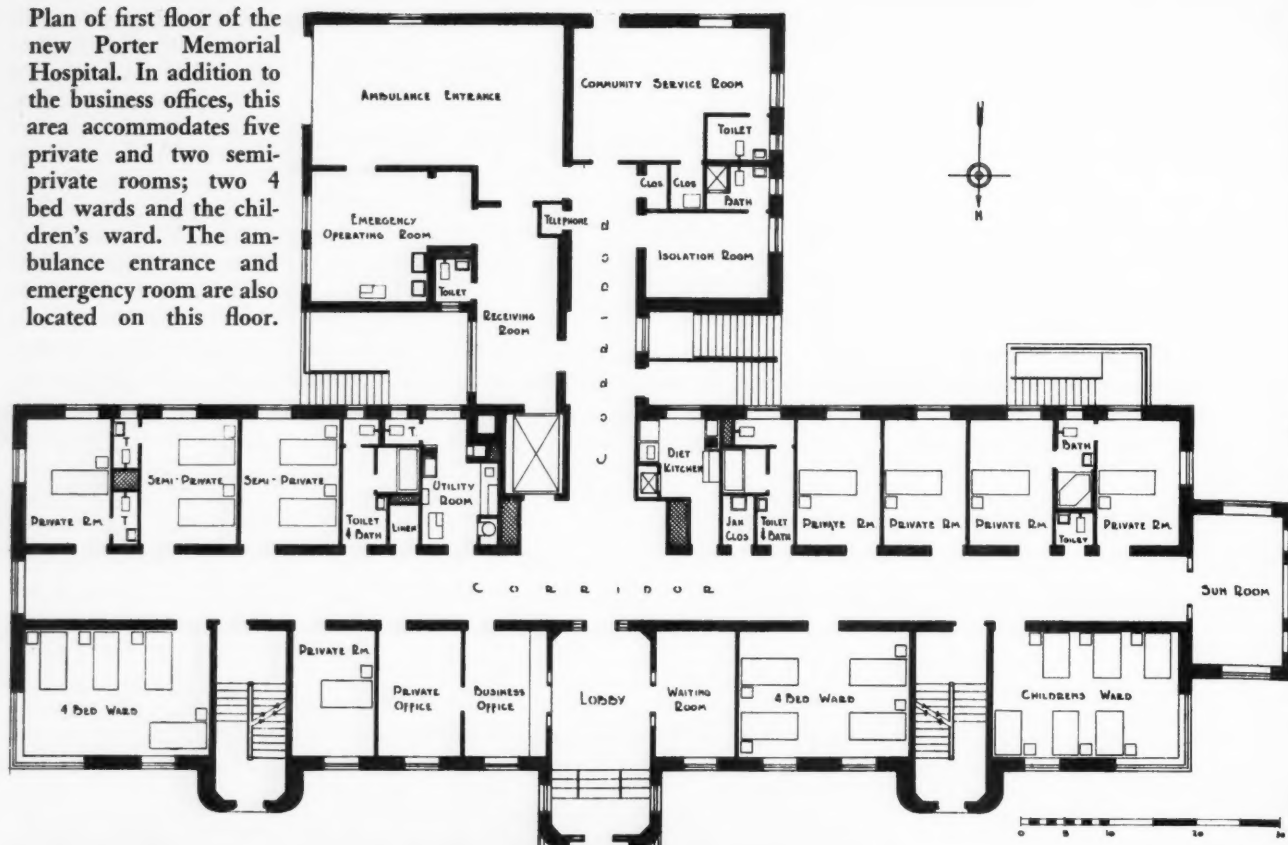
Planting should be done either in the spring or early fall but never in the hot summer. The material should be planted as soon as it arrives or it should be heeled in and protected from drying out until it can be planted. Every plant should be placed in a bed or hole filled with good fertile soil. The roots of a plant delivered bare should be spread out and covered with top soil, which should be thoroughly compacted about them by tamping. Plants that come balled and burlapped should be set at the proper depth in the holes and as much of the burlap as possible cut away without disturbing

spoil piles and the subsoil contour should be revised to conform to within 6 inches below the finished grades. This allows for the placing of 6 inches of good top soil over the subsoil, which thus will bring the new ground surface to finished grade.

In many cases there are valuable shrubs and small trees in the areas to be graded. Whenever possible this plant material should be taken up and replanted in an area set aside as



Plan of first floor of the new Porter Memorial Hospital. In addition to the business offices, this area accommodates five private and two semi-private rooms; two 4 bed wards and the children's ward. The ambulance entrance and emergency room are also located on this floor.



Above: Exterior view of the hospital showing the use of glass block panel windows in operating rooms and over entrances. Right: Detail of the entrance to the building.



PORTER MEMORIAL

LOUISE L. HIATT, R.N.
Superintendent

OUTLINE OF

GENERAL DATA: Porter Memorial Hospital, Valparaiso, Ind., 2.56 acre site. Capacity, 48 beds, not including bassinets. Service area, city population of 9000 and surrounding countryside.

CONSTRUCTION: Fireproof throughout. Face brick exterior with aluminum trim. Concrete joist construction, wall bearing. Interior partitions, hollow tile. Aluminum entrance doors and double-hung windows. Interior door frames and trim, sanitary metal. Glass block panel windows in operating rooms and over entrances.

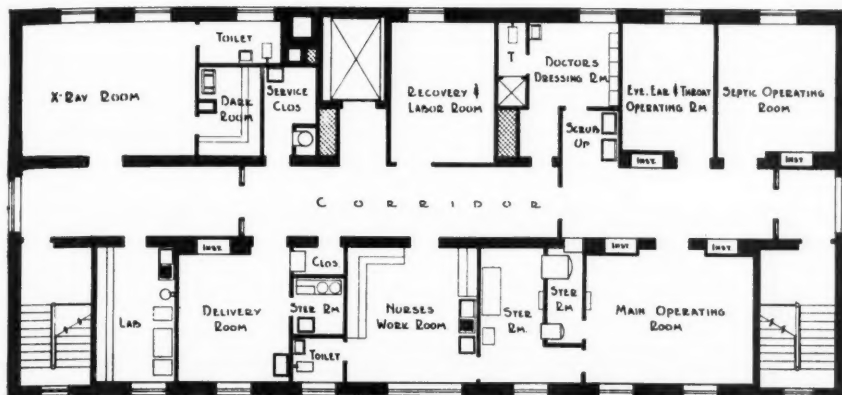
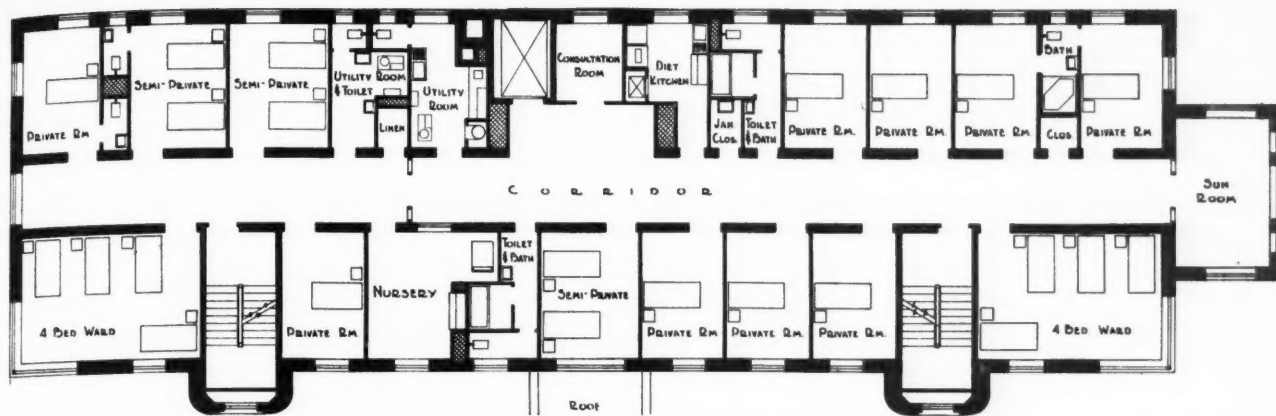
WALLS AND CEILINGS: Plaster, decorated in most areas. Ceilings in corridors and delivery rooms, acoustically treated.

FLOORS: Terrazzo floor and sanitary cove base generally; rubber tile in corridors; quarry tile and base in main kitchen.

ELEVATOR AND DUMB-WAITER: Full automatic, self-leveling elevator. Automatic dumb-waiter, serving all diet kitchens from main kitchen.

HEATING: Two high pressure boilers generating and distributing steam at low pressure to a vacuum steam heating system, at medium pressure to sterilizer and kitchen equipment and at high pressure to laundry equipment and for water heating.

LIGHTING: Especially designed fixtures for operating rooms.



Above: Second floor plan. The maternity division, comprising private and semiprivate rooms and a ward, is located on this floor. The nursery adjoins it. Left: The third floor is devoted to operating rooms and the laboratories.

HOSPITAL, VALPARAISO, IND.

WALTER SCHOLER

Architect, LaFayette, Ind.

CONSTRUCTION DETAILS

KITCHEN: Noncorrosive alloy finish on all equipment. Cooking units generated by gas, electricity and high pressure steam.

REFRIGERATION: Separate units.

LAUNDRY: Automatic washer, extractor, press and single roll ironer.

X-RAY: Complete diagnostic and therapeutic equipment.

MISCELLANEOUS: Complete instrument and utensil sterilizers, warming cabinets, surgical instruments.

COSTS: Volume 238,589 cubic feet:

General construction	\$143,507
Plumbing, heating, ventilating	39,556
Electric wiring and light fixtures....	12,973
Kitchen equipment, laundry, refrigeration	11,714
Portable furniture, draperies, shades	9,963
X-ray equipment	6,880
Sterilizers, surgical and technical equipment, instruments	13,159

Total

Per cubic foot, 99.65 cents.

Per bed, \$4953.27.

Architect's fee of 6 per cent not included.

FINANCING: P.W.A. grant for 45 per cent of cost; remainder by county bond issue of \$120,000 and gift of \$25,000 from David J. and Hannah J. Loring Trust Fund.

Right: One of the operating rooms on the third floor. The lighting fixtures were designed especially for the hospital. Below: The nurses' station on the first floor.



Rotation Therapy in Cancer

S. J. HAWLEY, M.D.

Roentgenologist, Geisinger Memorial Hospital, Danville, Pa.

SURFACE lesions that are sensitive to x-rays can readily be treated and in many instances cured because it is possible to apply as much radiation as is necessary directly to the lesion. The results obtained with deep-seated tumors are not as good because much of the radiation is absorbed in the normal tissues overlying the lesion. Several methods are in use to build up the total amount of radiation in a deep-seated lesion.

The commonest of these is the cross-fire method. In this procedure beams of x-rays are directed at the deep-seated lesion from four different directions as a rule, the x-rays entering through different parts of the skin. In each part the maximum effect takes place on the skin and the effect decreases as the beam penetrates more deeply into the body. In thin subjects it is possible to build up a large dose into a deep-seated cancer, such as a cancer of the uterus or the esophagus. However, the amount that can be given in every case is limited by the amount of irradiation that the skin and superficial structures will stand.

Attempts have been made to move the tube in an arc over the patient, holding the beam centered on the lesion to be treated. This spreads the dose to the superficial tissues over a larger area, thereby reducing the effect on any unit of skin area. Moving the tube is fairly cumbersome because of its weight and the problem of maintaining the electrical connections and at the same time protecting the patient.

The idea of rotating the patient was first suggested by Meyer in Germany in 1914. At that time shock-proof apparatus was not available so the idea was not developed. Dr. Wheeler P. Davey, professor of research physical chemistry of Pennsylvania State College, suggested to me in 1934 the idea of rotating the patient. This idea has been simultaneously worked out by Du Mesnil de Rochemont in Germany and Des-sauer in Constantinople.

The procedure is quite simple. It can be used with an existing shock-proof apparatus which allows turning the tube head so that the x-ray beam will be horizontal. All that is necessary to add is a turntable on which there is a suitable seat arrangement so that the patient will stay in position and will not become fatigued during the treatment, inasmuch as he must remain erect.

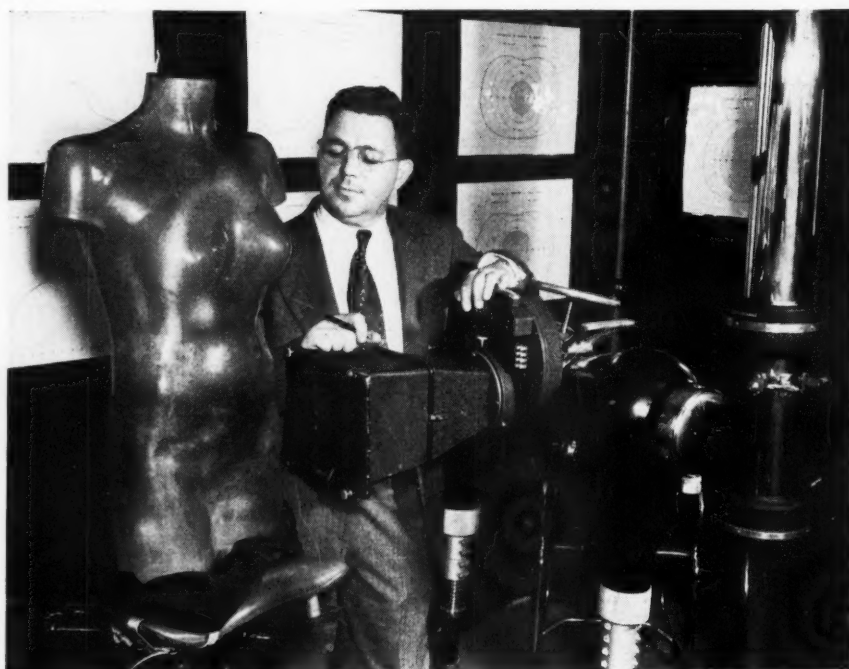
The arrangement in use at the present time consists of a small bicycle seat so fixed on a turntable that it can be moved forward and backward or, by turning the seat 90 degrees, to the right or left, thus enabling the operator to put any part of the body except the extremities over the axis of rotation. The seat can be raised for patients of different heights and it can be tipped for greater comfort. All the supporting mechanism is between the patient's legs so that there are no obstructions to the beam of x-ray.

The turntable is a simple one run by an electric motor with a pulley and belt arrangement to reduce the speed. It turns at the rate of once a

minute. A strap attached to a swivel joint in the ceiling may be used for the patient to hang on to if further support or steadying is necessary.

By placing the area to be treated on the axis of rotation and by turning the patient during the treatment, the area to be treated remains in the beam at all times. Each portion of the surface moves through the beam only during a part of each rotation. This procedure results in spreading the surface dose to the superficial tissues over a large area; furthermore, these tissues are radiated only intermittently, while the volume around the axis of rotation is rayed continually. This allows treatment of deep-seated lesions with little damage to the normal superficial tissues.

Several other advantages accrue from this method of treatment. The radiation is symmetrically and evenly distributed within the body. Variations in the shape of cross-section have little practical effect on the distribution because, as the body rotates, variations in the diameter are averaged out. The ratio of skin to deep dosage is more advantageous in large patients. This is the reverse of what has been found in cross-firing.



Doctor Hawley demonstrates the rotation method of treating cancer. This method makes it possible to administer large dosages without injury.

Preparation for Surgery

Newer Technic of Disinfection

PHILIP B. PRICE, M.D.

Associate Surgeon

Johns Hopkins Hospital, Baltimore

A RECENTLY discovered test makes it possible for the first time to count the number of bacteria on skin. As a result, several long-standing uncertainties in the matter of skin disinfection have been cleared up. There have been interminable arguments, for example, about the relative merits of various germicides when applied to skin, inevitably so because no one has really known how many bacteria there are on skin before a given disinfectant is used nor how many live, potentially dangerous bacteria remain there afterward.

Now, however, the precise effect of any given germicidal solution can be estimated in terms of the percentage of skin bacteria killed. It has become possible to say with assurance: "This disinfectant used on skin is effective; that one is not."

Again, there have been many methods used in different hospitals to prepare hands for operation and no one has been able to prove that one technic is better than another. In the future there need be no uncertainty about it. The methods can be evaluated.

Some time-honored technics for scrubbing and disinfecting hands have showed up badly in recent tests in that they have been found to reduce the bacterial flora of the hands and arms by only about one half, say from 10,000,000 to 5,000,000 germs. The best of the methods recently examined showed approximately 10 per cent of the microorganisms still alive and potentially infectious when gloves and gown were put on. So a new technic has been worked out that is capable of reducing the original bacterial flora to less than 2 per cent.

On the basis of the new bacteria counting test, many of these familiar antibacterial procedures and agents have been evaluated. Some have been found good; others have proved worthless and probably should be discarded. Although much remains to be done, a start has been made in developing effective new technics to

meet the important problem of skin disinfection. The following recommended practices have been evolved as a result of this investigation.

Hand Scrub: Nails should be short and clean at the start. Scrub vigorously with brush and soap in warm water for seven minutes on the average, exclusive of any time taken out for scraping under the nails. Dirty, greasy hands will require longer brushing; immaculate, recently scrubbed hands, somewhat less. Vigorous scrubbing accomplishes as much bacteriologically in seven minutes as languid scrubbing does in ten or fifteen. Brushes softened by much sterilizing or soaking should be avoided.

The kind of soap used does not matter much provided it is bland. Warm water is preferable to cold only because it is more comfortable

Doctor Price puts some long cherished theories about skin disinfection under the microscope and makes the discovery that many of them have "bugs"

and because it enables soap to emulsify and remove grease more efficiently. Sterile water has no advantage over ordinary tap water in disinfecting hands.

Chemical Disinfection of Hands and Arms: After scrubbing, dry well with a sterile towel and then wash briefly in a basin of 95 per cent alcohol to remove any remaining water. Wash for 3 minutes by the clock in 70 per cent (by weight) alcohol, rubbing the solution on the skin all the while with gauze or wash cloth. Finally, if dry gloves are to be worn, dry the hands thoroughly on a second sterile towel.

Gloves: Dry gloves are preferable to wet provided they are perfect (without holes and unpatched) and their care and preparation are in competent hands. Wet gloves are more economical, however; they are also more easily and certainly sterilized and any holes or leaks can be readily detected while putting them on.

Live bacteria left on skin after disinfection multiply fairly rapidly under rubber gloves, whether dry or wet. Any pathogenic organisms present participate in this increase. No antiseptic powder or solution has been found that will prevent the increase of cutaneous bacterial populations under gloves. Hence, if gloves are changed during or between operations it is important to redisinfect the hands, using the 70 per cent alcohol for the purpose. A useful rule is "one minute in the alcohol basin for each hour gloves have been worn."

Disinfection of Field of Operation: The skin of the entire body is densely populated with bacteria. As a rule, protected skin has higher counts than exposed skin. The problem is to sterilize the field of operation almost instantaneously, *i.e.* to kill all its bacteria by a single application of one or two "strong" germicides without injuring the skin. Actually, this cannot be accomplished. The best that can be hoped for is to reduce the flora as much as possible and hope that the remaining organisms are of low virulence. But if a patient should have a discharging pyogenic infection anywhere, such as a sore throat or a boil on the neck, his skin everywhere is likely to be seeded with pathogenic organisms.

Disinfection of the field of operation should be guided by four general principles. First, free the skin from extraneous grease and oily secretion since these protect bacteria from the action of most chemical

agents. Second, use germicides that have proved their worth as cutaneous disinfectants. The phenol coefficient test cannot be depended upon in this connection. Third, apply the germicidal solution thoroughly to every part of the field. Use a reasonable amount of gauze friction because that will improve contact between the chemical and the bacteria and thereby will increase the total germicidal effect. Fourth, allow time for the solutions to act. In chemical disinfection, especially on skin, there is a relatively slow "reaction" between bactericide and bacteria. It cannot be hurried. To apply iodine, for instance, and then to fan the surface to hasten drying defeats the purpose of the disinfectant because, once dry, iodine, in spite of its splendid color, has virtually no effect upon the remaining bacterial flora.

Simple Technic Developed

The following technic has been shown by the new bacteria counting test to be dependable and quite effective.

1. Make no preliminary preparation of skin other than ordinary bathing and, when required, shaving.
2. Rub the site of operation well, even vigorously, with gauze sponges and an abundance of 70 per cent (by weight) alcohol solution for three minutes by the clock.
3. Dry the skin with dry or ether sponges.
4. Apply iodine, using 7 or 3.5 per cent alcoholic solutions ordinarily, and 2 per cent on delicate skin. These solutions are considerably more bactericidal on skin if prepared with 70 per cent (by weight) alcohol rather than by the standard U.S.P. formulas. They have advantages of even spread and slow drying.
5. After applying any of them, allow two or three minutes for germicidal action to take effect and then wash off with 70 per cent (by weight) alcohol.
6. Drape.

Disinfection of Contaminated Hands: The "resident" portion of the bacterial flora of skin is difficult to reduce and almost impossible to eliminate altogether. Fortunately, however, contaminating bacteria can be removed or killed relatively easily. Handling infected patients, wounds or material with bare hands is not without risk but is often necessary.

The following procedure has been shown experimentally to be capable of freeing the hands from test-bacteria rubbed on them; it is, therefore, recommended for clinical trial. Handle the infectious object only with clean, grease-free hands. Limit contamination, if possible, to the palmar surfaces. Then wash without delay in running water with soap for half a minute or more. This will remove perhaps nine tenths of the contaminating organisms. If there is blood, pus or mucus on the hands, washing must be prolonged. Brushes must be used with caution because of the danger of rubbing pathogenic organisms into hair follicles or nail folds. Dry the hands thoroughly on paper towels, then wet them with a few cc. of 70 per cent (by weight) alcohol and permit them to dry slowly by evaporation.

It should be mentioned in this connection that rubber gloves that have been contaminated during operations cannot be sterilized by washing them hurriedly in an antiseptic solution. Tests have shown that as long as three minutes of scrubbing with brush and soap may be required to remove all contaminating bacteria from gloved hands. When gloves are thought to be contaminated, it is best to change them.

Effects of Various Germicides

Evaluation of Certain Skin Disinfectants: Ethyl alcohol is universally popular, but the solutions most commonly used at present (95 per cent and 70 per cent by volume) have relatively little germicidal strength. It is only beginning to be appreciated that exactly 70 per cent by weight (*i.e.* 70 gm. pure alcohol to 30 gm. water) is the most effective concentration. Properly prepared, this solution is powerfully bactericidal and is one of the best skin disinfectants available, but even slight deviations from this particular concentration reduce its potency.

Ether has some value as a detergent but it is incapable of reducing the "resident" bacterial flora of skin appreciably.

Mercuric chloride (bichloride) and potassium mercuric iodide (biniodide) have a peculiar action on skin. They react in some way with the skin to form an invisible, tough, thin film that covers the skin surface. Comparatively few cutaneous bac-

teria are injured in the process; they are merely imprisoned by the film and proceed at once to multiply at a rapid rate as they do under rubber gloves. Later, when the film breaks up as the result of friction, an unusually large number of flora is released. If these solutions are used frequently, the hands develop abnormally high bacterial counts which it is difficult to reduce by ordinary means.

Mercurochrome in aqueous solution has an effect on skin that is quite similar to that just described for mercuric salts. Alcohol-acetone 2 per cent solution of mercurochrome has a like action except that it also kills some of the bacteria present (as much as two thirds of the flora) but those that are left commence at once to propagate.

It probably is advisable before painting a part preoperatively with any mercurial solution to attempt to degerm the skin (with alcohol, for example) and to expect the mercurial to provide only a germ-free surface such as would be produced by a coating of collodion on the skin. Should disinfection not be carried out before applying the mercurial, knife and needle will pass through germ-laden skin and any abrasion of the "film" will release some of the imprisoned cutaneous bacteria.

Tincture of iodine must be given a high rating among skin disinfectants. Two per cent iodine in 70 per cent (by weight) alcohol reduces the bacterial flora to about one sixth its original size in two minutes. Stronger solutions are even more effective.

Compound solution of cresol has a high phenol coefficient rating because it is actively bactericidal in vitro but on skin it has been shown to be practically useless as a disinfectant.

Neutralized by Soap

"Zephiran" is a new germicide of considerable potency but, unfortunately, its antibacterial action is neutralized by soap. Even traces of soap that linger on skin after thorough rinsing with water are sufficient to nullify much of its potential disinfectant action. If the agent is to be used on the field of operation, the skin should first be washed well with a soap solvent, such as 60 per cent (by volume) alcohol solution.

Depreciation Costs

JAMES V. CLASS

Comptroller, University Hospitals, Cleveland

A Problem in Hospital Finance

EXISTING hospital equipment and buildings are depreciating continuously and sooner or later must be replaced, a fact that gives rise to concern as to how the replacement will be financed. Private philanthropy cannot be counted on as it has been in the past and the present trend toward contract service—much of it at rates below cost—does not offer immediate possibilities for surplus accumulation. As a result, there appears to be more interest at present in all of the economic and accounting aspects of hospital depreciation than ever before.

The term "depreciation" in its strictest sense refers to the decrease in value of durable assets caused by ordinary usage, erosion or similar causes over a period of time. In addition to the wear and tear factor, such items as obsolescence and inadequacy are frequently included in general economic consideration of the subject. One is entirely justified in saying that no statement of the cost of producing services should be considered complete unless it includes provision for this gradual or eventual diminution of plant value.

Wear and tear will eventually produce a condition that makes continued maintenance efforts uneconomical. Efficient maintenance may defer that time but ultimate replacement cannot be avoided. Obsolescence occurs when the asset becomes outmoded and when better or more economical service can be obtained from newer equipment. Inadequacy may occur when the asset is not equal to the demands placed upon it and ordinary expansion is not practicable.

The object of charging depreciation arises through our established economic structure, which requires the consumer of services to return the full cost of such service or commodities for distribution to the investors or to a fund that is being accumulated to replace the institution as required. Voluntary hospitals are usually constructed from donations of individuals and from charges to patients in excess of the day-to-day operating expenses and do not have

Administrators who regard depreciation costs as something that should be left severely alone will be grateful for Mr. Class' efforts to clarify this troublesome problem

the problem of rendering an accounting to investors. Return to the donors is out of the question but it is important that institutions plan to continue their usefulness when the present plant is worn out.

The propriety of charging depreciation in a charitable institution donated by the public might be questioned, but recent economic trends have indicated that the future holds no promise of new financing comparable with the lavish donation system that prevailed up until about 1930. Formerly, many donors would have resented any attempt to develop rate schedules sufficient to return the plant investment to a permanent replacement fund, but now there are indications that the voluntary hospital must be prepared to finance future replacements by new methods.

A rapidly increasing proportion of service is now being rendered to patients who are participants in some nonprofit or commercial group plan. In addition, there appears to be an increase in other types of contract work. So far as is known, none of the nonprofit plans are recognizing provision for plant replacement in their reimbursement rates to the hospitals. On the other hand, the group plan subscribers usually believe that full cost of care is being met. It is this developing attitude that is giving concern to some hospital economists who foresee difficulties when the time comes to finance extensive replacements.

An executive of one of the large industrial insurance companies re-

cently took a group of hospital administrators to task for being negligent in that they did not include depreciation in their rate structures. He stated that industrial group plan premium rates are established in a community by correlating the industry's low income levels with the lowest cost of hospital care obtainable. He stated that there is no reason why the indemnity rates paid by insurance companies could not be made sufficiently high to take care of the full cost of ward care including depreciation.

The mere placing of a charge for depreciation in a hospital's expense accounts will not solve all problems. Many patients will have no more money to pay for care than they have had in the past, but a thoroughly understood knowledge of the complete cost of rendering care will make it possible for institutions to deal more intelligently in establishing contract and noncontract rates and in budgeting free and part-pay services.

Many individuals appear to be fearful of the subject of depreciation because of experiences with and observations of the many and complex problems that arise in commerce and industry. The subject, however, is extremely simple in its fundamental form and the complexities have usually occurred because of federal and state tax laws in which the retirement of plant cost is an important item.

But voluntary hospitals are not affected by such laws and have an opportunity to establish a code of accounting principles and procedures that will be simple, practicable and entirely adequate to meet the demands.

Ordinarily, depreciation is based on the cost of the property and an attempt is made to estimate its useful life and then to establish a pro-rata annual charge to operating expense. Original cost is a common basis of valuation because of federal and state tax laws. Hospitals, however, would

Depreciation Charges per Bed and per Patient Day*

Cost per Bed	Number of Years to Amortize Cost					
	30 years		40 years		50 years	
	Per Year	Per Day	Per Year	Per Day	Per Year	Per Day
\$ 3000.....	\$100	\$0.323	\$ 75	\$0.242	\$ 60	\$0.194
5000.....	167	.539	125	.403	100	.323
7000.....	233	.752	175	.565	140	.452
9000.....	300	.968	225	.726	180	.581
11,000.....	367	1.184	275	.887	220	.710

*Figures are based on 310 days per year, or about 85 per cent occupancy.

be entering into this subject with intent to establish a fund to perpetuate the institution and, therefore, should use a charge based on the cost of reproducing a new plant capable of rendering service at least equal to present standards. Industries frequently use reproduction value in establishing production cost even though an adjustment must be made for tax calculations.

There is great variety in methods of applying the periodic charge to operating expense, ranging all the way from elaborate tabulations of carefully worked out engineering estimates of the life of each individual item on down to extremely simple calculations based on the plant as a whole. Public utilities and other corporations that sell a complete service frequently use a composite average annual rate based on the entire plant value. Hospitals would be well advised to use a similar method rather than to attempt to break the investment down into many groups with various annual rates.

It was shown by C. Rufus Rorem* in 1928 that general voluntary hospitals had an average investment of about \$6200 per bed although individual institutions ran as low as \$3000 and some went as high as \$15,000 or more. Mr. Rorem was of the opinion that well-constructed, fireproof, completely equipped general hospitals of 100 beds or more could not be built for much less than from \$4500 to \$6500 per bed. Extensive data on comparative construction costs are not readily available because of the small number of hospitals constructed during the last ten years but it should be possible for most institutions to establish a fair valuation on which to base a reasonable charge.

*Rorem, C. Rufus: *Public's Investment in Hospitals*. Chicago: University of Chicago Press, 1930.

If the hospital is comparatively modern, completely equipped and has accurate records of the original cost plus subsequent major additions, those figures should be entirely satisfactory to use. If accurate figures are not available it should be possible to establish a sound basis by some study of existing data. The service of professional appraisal companies is always available but it is questionable whether the average hospital needs to go to the expense of such a service to accomplish this purpose.

The tabulation submitted here shows the annual depreciation charge per bed for various periods of the life of the hospital at several average bed costs. The tabulation further shows the cost per patient day at approximately 85 per cent occupancy. It will be observed that a hospital costing \$5000 a bed, using a forty year life estimate (2½ per cent annual rate), would have a charge of only slightly more than 40 cents per patient day. From this tabulation it is apparent that many troublesome questions as to basic valuation or annual rate of charge lose much of their apparent significance when figures are reduced to an average cost per patient day.

Questions will arise as to the proper method of handling replacements, minor equipment additions and extraordinary maintenance, all of which may seem to prolong the life of the plant.

Many institutions, for example, have adopted the policy of absorbing into current operating costs expenditures which sustain, but do not materially expand, the scope of the existing institution. Where there is a definite expansion or inauguration of a completely new service, the cost of the expansion should be charged to the plant asset account. In spite of all that has ever been written on the theory of depreciation, com-

mon sense in the light of surrounding circumstances remains the best rule. No general formula has ever been devised to determine when some types of expenditures should be charged against the capital account and when they should be charged against current operations.

It is not possible, within the scope of this article, to deal with the economic and administrative problems connected with the actual establishment of a separate fund to accumulate the amount reserved for depreciation. Needless to say, many different problems are involved. Such a fund, however, is essential or a considerable portion of the benefits from the accounting and rate structure programs will be lost.

If voluntary hospitals undertake to include depreciation as a cost, the accounting should be arranged so that the data can be used to good advantage in public relations. It will still be impossible for a good many hospitals ever to get a return from all patients that is equal to the full cost of care; hence, statistical and financial data showing the volume of service on which full cost cannot be realized should be kept so that the institution will still be in a position to ask for community assistance in providing care for those who are unable to pay full rates.

Administrators will raise many questions about various details as they get into the subject. The question of the salvage value at the end of the estimated life of the plant may seem important. Another troublesome item will be extraordinary repairs or replacements. Many different theories will be advanced and arguments will be propounded for their adoption.

Hospital administrators and accountants both, however, will do well to avoid most of these troublesome details until the simple fundamentals are thoroughly understood. Regardless of all of the confusing arguments and theories, what the voluntary hospitals would actually be undertaking is to establish an annual operating charge which, if incorporated in the rate structures, would require paying patients to contribute to the replacement of the institution over a reasonable period of years. Such a charge, as has been demonstrated, is neither unreasonable nor excessive.

Organizing the Auxiliary

With Service as Its Goal

THE hospital auxiliary requires sound organization if it is to render the service that is fully expected of it. Like any structure that is destined to attain substantial proportions, it must have a solid foundation on which to build. The failure of such groups to realize their full potentialities may generally be traced to some inherent fault incurred at the start. It is wise, therefore, to move slowly, but surely, with some knowledge.

Why Have an Auxiliary?

Before even taking the first step, there must be a logical answer to the question, "Why an auxiliary?" Granted that few hospitals today can afford to operate without an auxiliary and that increasingly important services are being rendered by these groups, sentiment must be unanimously in favor of the enterprise. There must be no question as to the attitude of the hospital administration, of the board, of the community. There must be a leader who is sufficiently imbued with the idea to labor patiently and diligently in its behalf and who possesses as well the power to vitalize the spark of unselfish service that lies dormant in others. There must be a clear concept of the precise functions of an auxiliary and how they can be coordinated with the hospital program.

The first definite step should be an organization meeting. It is highly desirable that this be sponsored by the hospital's board of directors. It should be planned, too, with the help and guidance of the administration. The purpose is to interest as many different types of women as possible. Included in the list will be those who are prominent in church affairs, in public welfare, in education and in the general civic life of the community. This group should be presented with the facts, *i.e.* the precise functions of the auxiliary as set up by the leader or leaders and by the hospital administration.

It is better to start with one or two comparatively simple projects and

fulfill them than with an elaborate program that, it is discovered later, cannot possibly be realized. Assisting in furnishing linen replacements, building good will, supplying funds to meet one or two specific needs, providing holiday programs and decorations for both patients and the staff are some excellent projects suggested by William B. Sweeney, superintendent of Windham Community Hospital, Willimantic, Conn.

If possible, one year's program should be definitely outlined at the time of organization. This will avoid any tendency on the part of members, individually and collectively, to inject at future meetings random ideas that will prove distracting and confusing. There must be no deviation from the goal.

Name Officers and Committees

At this first meeting, too, attention should be given to the naming of officers, adoption of by-laws and the appointment of such subcommittees as are needed immediately. Again, caution is urged in establishing too many committees at once.

Much depends upon the individual who is selected as the leader of the group. Not only does the president or the chairman of the auxiliary serve as presiding officer and appoint committees or make recommendations to her executive committee of those who may be appointed but she assumes the responsibility of carrying out the program and policies that have been established.

In addition to this leader, of whom so much is expected, there must be other officers who exemplify leadership, a vice president, a secretary and a treasurer. These, and others who seem particularly fitted, can comprise the governing board. Members of the governing board may be made responsible for carrying out specific projects, thereby becoming the chairmen of the different committees. Next, the formulation of suitable

by-laws should come up for consideration. Again, simplification is recommended. Six or seven "articles" should suffice.

First, there is the official name of the organization. Next, may come a brief outline of its purpose. For example, "The purpose shall be to render to the hospital any assistance that may lie within its powers." Also included should be some statement to the effect that "the auxiliary shall not enter into any project outside of its own organization without the approval of the board of governors."

The next article might very well have to do with membership. Who is eligible for membership? How are members elected and what dues will be required? Dues generally range from \$1 to \$5 a year.

There should be a section on officers and committees, in which are outlined briefly the officers and their functions, as well as the setup as it affects various committees.

An article on meetings should be included. There will probably be annual and regular, *i.e.* monthly, meetings; as well as special meetings. At the annual meeting 30 per cent of the members will constitute a quorum. At regular meetings 40 per cent of the membership may constitute a quorum.

Article on Amendments

It might be well to include an article on amendments worded as follows: "These by-laws may be amended after notice has been given at any regular meeting. Such notice shall be laid upon the table until the next regular meeting and shall require a two thirds majority of those present for adoption. Amendments so made shall be effective when approved by the board of governors."

Finally, "these by-laws shall be adopted at any regular meeting and shall become effective when approved by the board of governors of the hospital. They shall, when

adopted and approved, be equally binding on the governing board and the auxiliary."

For those who would become familiar with parliamentary law the book, "Parliamentary Practice," by Gen. Henry M. Roberts is recommended. Also, for more complete information on by-laws, it is suggested that reference be made to the volume "Hospital Organization and Management," by Malcolm T. MacEachern, M.D.

Should the hospital be located in a rural community, Mr. Sweeney

points out that small groups might well be organized in the various towns, either through the church or the grange. The chairmen of these groups are included on the board.

An interchange of ideas with others is always stimulating. This is possible today through attending hospital meetings in which auxiliary sessions are scheduled and reading hospital magazines. In preparing programs for regular and annual meetings, efforts should be made to provide speakers who will inject new ideas. The hospital administrator and

department heads should be invited to participate so that every member will get the complete hospital picture.

Most important of all for the success of any auxiliary is vigilant control by the executive officer over the entire membership to ensure harmony and good teamwork and to avoid interference with administrative activities.

The scope and variety of activities in which auxiliaries engage on behalf of their hospitals are revealed in the answers to a questionnaire that were received from 13 hospitals.

• • • •

• LILLIAN M. McDONALD, R.N., *Salem General Hospital, Salem, Ore.* (72 beds).

1. There are 289 members in our auxiliary. We have no junior group.

2. The auxiliary raises money for a definite project each year. The funds are obtained through membership dues, teas and rummage sales. About \$575 was raised in 1940. In 1937, 1938 and 1939 the money was spent for a new oil burning heating system, which cost \$1400. In 1939, 1940 and 1941 the auxiliary concentrated on remodeling and obtaining new equipment for the main kitchen. When this project is completed it will probably cost around \$2500.

3. No personal service is rendered. Flowers are sent to the hospital for all special occasions.

• MARJORIE M. IBSEN, *Highland Park Hospital, Highland Park, Ill.* (55 beds).

1. We have 300 members, with an average of 60 attending the monthly meetings. The junior and senior groups were recently merged.

2. Before the auxiliary was on the "receiving end" of our local community chest, the annual membership fee was \$10. Then, with the usual parties, concerts and bazaars, the members were able to accomplish a great deal. At present, the membership fee is \$1. Approximately \$2000 comes from the community chest. The thrift shop, memorial fund (in lieu of flowers) and the Happy Day fund net about \$1500 annually.

The purposes for which our auxiliary organized are to assist the hospital board of managers in maintaining modern equipment and furnishings and to assist needy patients.

In 1939 the auxiliary gave \$10,000 (which had accumulated in the memorial fund) toward the cost of installing

a new elevator. In addition, it gave new draperies and screen covers for 25 rooms, 12 bedside lamps and 30 bedside tables, an infant resuscitator and an obstetrical table.

In 1940 it refurnished the doctors' consultation room and the reception room, completely remodeled and refurnished the superintendent's office, bought a flatwork ironer for the laundry and a new anesthesia machine for the emergency room.

Thirty-two needy patients were aided, either by outright gifts or by loans, depending on the needs of the individual.

This year we have set up a special nursing fund which enables us to call a special nurse for patients who need such care but who are unable to afford the luxury.

Medicines, milk and fruit are provided for home patients and between \$200 and \$300 is provided each year for dental care for patients.

THE QUESTIONS

1. How many members are there in your women's auxiliary? Do you have a junior as well as a senior auxiliary?

2. Does the auxiliary raise money for the hospital? If so, how? For what purposes? About how much is raised per year?

3. Do members of the auxiliary render personal service to the hospital (as clerks and librarians, or through flower and entertainment committees, for example)? What do they do?

4. Do auxiliary members aid the hospital by sewing or canning food or in other similar ways? Please tell what they do.

3. No, except as a "public relations" group.

4. The members do some sewing and also make dressings and the usual jelly.

• LOUISE SANFORD, *Addison Gilbert Hospital, Gloucester, Mass.* (85 beds).

1. We have about 300 senior and 35 junior members.

2. Money is raised from bridge parties, book reviews and lectures and by membership dues. The money is used to supply the hospital with linens.

3. The junior auxiliary has charge of the patients' library. The members also make surgical dressings and entertain student nurses.

4. Donation Day is held annually, at which time canned goods, fruits and vegetables are given to the hospital.

• BESSIE M. ROY, R.N., *Newton Memorial Hospital, Newton, N. J.* (42 beds).

1. There are 1361. Some of the 19 branches of the auxiliary have junior members.

2. Yes, through card parties, minstrel shows, operettas, sleigh rides, luncheons, cake sales, barn dances, skating parties, rummage sales and a "traveling basket." Between \$3000 and \$4000 is raised each year. It is used to buy new equipment and linen.

3. Auxiliary members serve in the library. There are also a flower committee and Hospital Day committee.

4. The members do a great deal of sewing for the operating room and make tray covers and napkins. Each of the 19 branches has a Donation Day in the fall when all canning that has been done throughout the summer is brought in.

• SISTER M. LIGUORI, *St. Luke Hospital, Pasadena, Calif.* (70 beds).

1. There are 200 members in good standing. A junior auxiliary has just

been organized for volunteer work in the hospital five mornings a week.

2. Between \$1000 and \$1500 is raised each year. The main objective is to replenish the linen supply. Other needs, such as buying small pieces of new equipment and renovating furniture, are met as they arise.

3. The junior auxiliary members render personal service only and do not enter into the fund raising projects.

4. An active sewing committee of at least six members meets twice a month in the hospital (from 10 a.m. to 4 p.m.) for sewing. They come every week at times when their services are especially needed. Once a year, i.e. the December meeting, the group as a whole gives the hospital a jam and jelly shower. Magazines are also sent in.

• L. F. BLUNT, *Weyburn General Hospital, Weyburn, Sask.* (50 beds).

1. About 30 members. There is no junior auxiliary.

2. Before the war they raised about \$1000 a year.

3. The auxiliary pays a woman \$1.50 a day to do sewing and mending for the hospital. There is a committee for visiting patients, and reading materials are provided if necessary.

4. Two years ago the auxiliary bought a new autoclave for \$1900. Last year it purchased four gatch beds, an oxygen cart and equipment for oxygen tanks and material for curtains.

• MABEL BARR, *St. Christopher's Hospital for Children, Philadelphia.* (82 beds).

1. There are between 20 and 25 members in the women's auxiliary. No junior auxiliary has been organized but women recommended by the women's board are used as volunteers in the out-patient department.

2. The amount raised each year ranges from \$1500 to \$4000. This is obtained from an annual emergency aid bazaar; the flower market, in which the auxiliary participates every four or five years, and the charity ball, in which it participates about every fifth year. The hospital is one of 10 institutions that receive benefits from a cooperative shop, which is run entirely by volunteers from the different beneficiaries. The income from the activities of the women's board is used entirely for special purposes other than maintenance.

3. Members of the auxiliary serve as secretaries in the out-patient department; convey patients to and from the clinics for appointments, and act as chairmen of committees of the out-patient, social service and preventive medicine departments.

• SISTER M. HENRICA, *St. Francis Hospital, Santa Barbara, Calif.* (85 beds).

1. We have about 500 members in our St. Francis Guild. This membership is not confined to women. We also have many men as members but not a junior guild.

2. The St. Francis Guild was not formed as a money raising organization but it finances the work (listed under question 3) carried on by the various committees. The primary function of the guild is to promote good will and to build a feeling of understanding between the public and the hospital.

3. The library supplies books and magazines to all patients. The children's committee gives flowers and a birth certificate to each new baby born in the hospital. This committee also sends a card on the baby's first birthday and puts favors on children's trays for all holidays.

4. The sewing committee meets regularly and accomplishes a great deal. A flower committee provides flowers for the needy patients and for the decoration of the hospital on special occasions.

• WILLIAM B. SWEENEY, *Windham Community Hospital, Willimantic, Conn.* (91 beds).

1. The women's auxiliary has a membership of more than 500 with subauxiliaries in each of our 12 community towns. We also have a junior auxiliary of 175 high school girls who, in teams of six, assist at the hospital afternoons and evenings.

2. The auxiliary has two major social events each year. In addition, it engages in fund raising activities in the community towns. It provides some new equipment and linen replacements and is now engaged in organizing a field nursing service for follow-up cases from the hospital. The subauxiliaries try to fill some of the needs listed in our traveling scrapbook. All of the auxiliaries assist in the annual fall Donation Day when surplus products of the garden and home preserves and canned goods are brought to the hospital.

3. No personal service is given by the senior group, but there is a great deal by the junior members. Flowers on wards and entertainment are provided by the senior auxiliaries on holidays.

4. Yes. We have a standard cutting committee which sends out boxes of garments to the various subauxiliaries for assembling. Electric sewing machines and boxes of dressing materials (with samples attached) are also sent out. Each box carries a list and number and credit is given to every unit.

• ESTHER SQUIRE, R.N., *Grinnell Community Hospital, Grinnell, Iowa.* (54 beds).

1. There are 150 members; no junior members.

2. The auxiliary raises money by a rummage sale, bake sale, dues and donations from various organizations in the city. This totals about \$500 a year. Linens and furnishings are purchased with the money.

3. There is no personal service but a nurses' committee furnishes library books and holiday tray favors for the patients. The auxiliary also sponsors a garden party and a baby party each year.

4. The auxiliary contacts all social and service organizations, the members of which, in turn, sew for us. It also sponsors a canned food shower.

Next to the satisfied patient, I consider the auxiliary as the best agent for promoting good will and interest for the hospital.

• SISTER FERDINAND, *St. John's Hospital, Salina, Kans.* (55 beds).

1. We have 100 members.

2. Money is raised through membership dues (\$1 a year), a card party and fruit and linen showers.

3. Once a month about 30 members sew for an hour or two. We serve a small lunch.

• E. R. CARNEY, *Parkside Hospital, Detroit, Mich.* (60 beds).

1. There are 40 members in the senior auxiliary.

2. In 1939, \$150 was raised. The money is raised by membership dues, bridge parties, plays and dances. It is used to pay the hospital's dues in various organizations, for subscriptions to hospital journals, for the nursery and for furnishings for private rooms.

3. The members serve as hostesses on special occasions, such as National Hospital Day and Christmas. They send flowers, magazines and Christmas cards to patients.

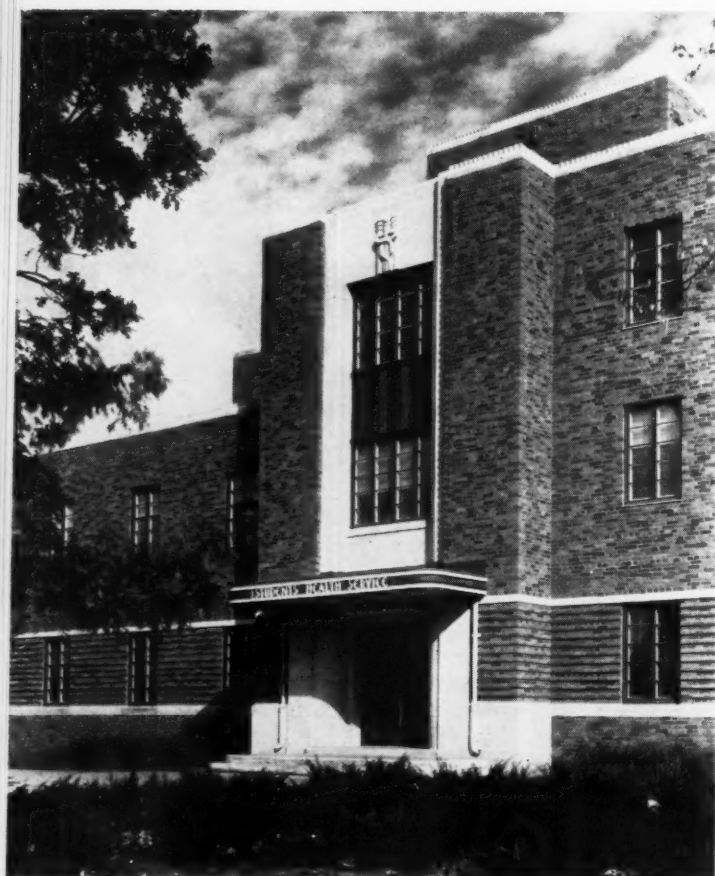
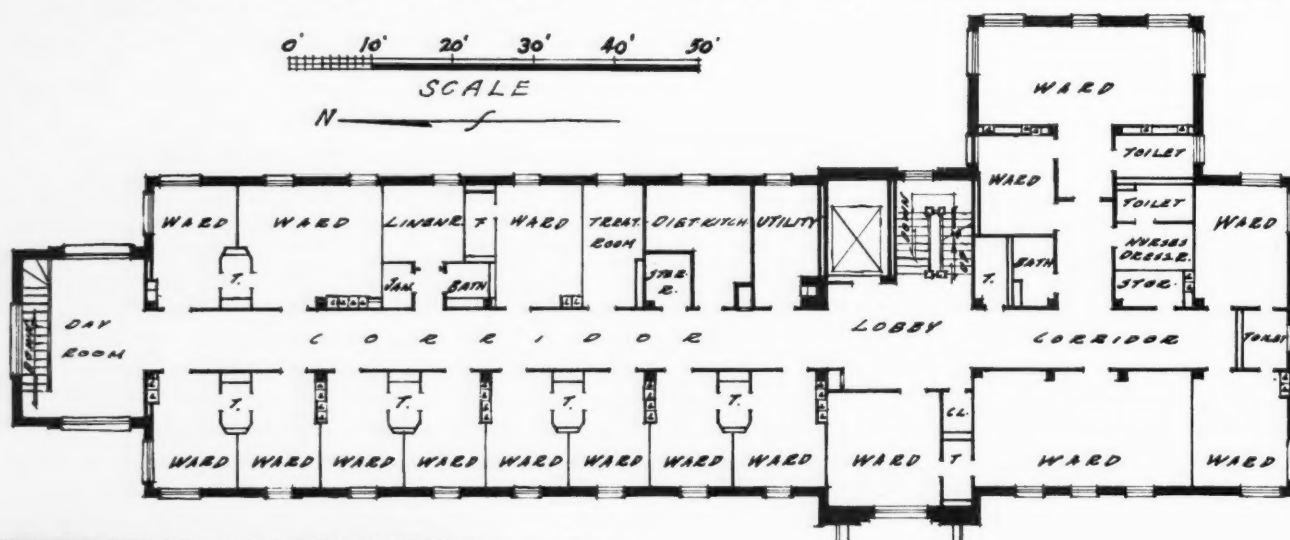
4. The auxiliary makes baby garments, bandages for patients and curtains for the hospital.

• I. CRAIG-ANDERSON, *St. Luke's Hospital, Davenport, Iowa.* (90 beds).

1. There are about 35 members in the auxiliary; no junior auxiliary exists.

2. Yes. A luncheon style show is given each year. This year it netted \$400. This will help pay for an orthopedic table. Last year the auxiliary contributed toward the nursing school and also bought awnings for the hospital windows.

UNIVERSITY OF MINNESOTA STUDENT HEALTH SERVICE



Left: The front entrance showing the use of Mankato gray stone as trim and the modernized caduceus. Below: Plan of the first floor. A small lobby divides the out-patient department from the nursing unit of 10 beds. Each of the ward rooms is large enough for an extra bed in case of epidemic.

CONSTRUCTION DETAILS

GENERAL DATA: Modern health center for students of University of Minnesota constructed at University Farm, St. Paul. Capacity, 39 beds, to be increased by 15 beds when third floor is completed. Wards planned and equipped for communicable disease patients, if necessary. Surgical patients cared for at main health service.

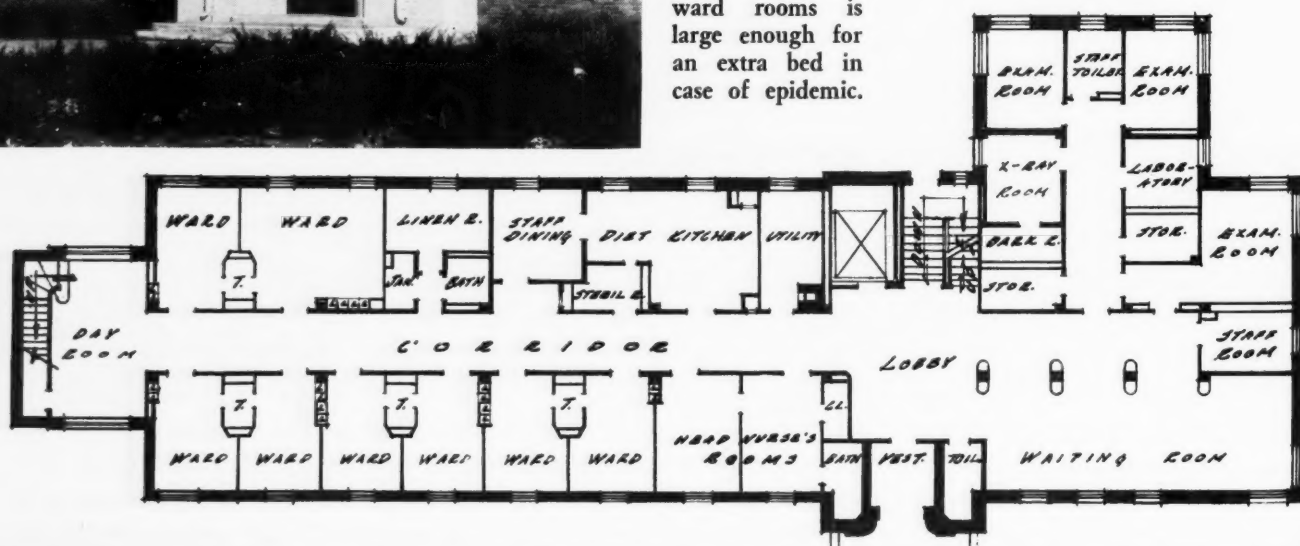
CONSTRUCTION: Exterior walls, native Springfield brick with Mankato gray ledge stone on entrances, steps, bands at first and second floors and on roof parapet copings. Windows, worm and gear operated casement type with aluminum sills. Principal stairway, steel construction; reinforced concrete stairs between solariums at north end of building.

FLOORS: Asphalt tile throughout except for silver gray nonslip tile in service rooms. Recessed rubber link mats at entrances.

ELEVATORS: Automatic, self-leveling.

HEATING: Serviced through central heating system on the campus.

CALL SYSTEM: Lamp annunciators.



ST. PAUL, MINN.

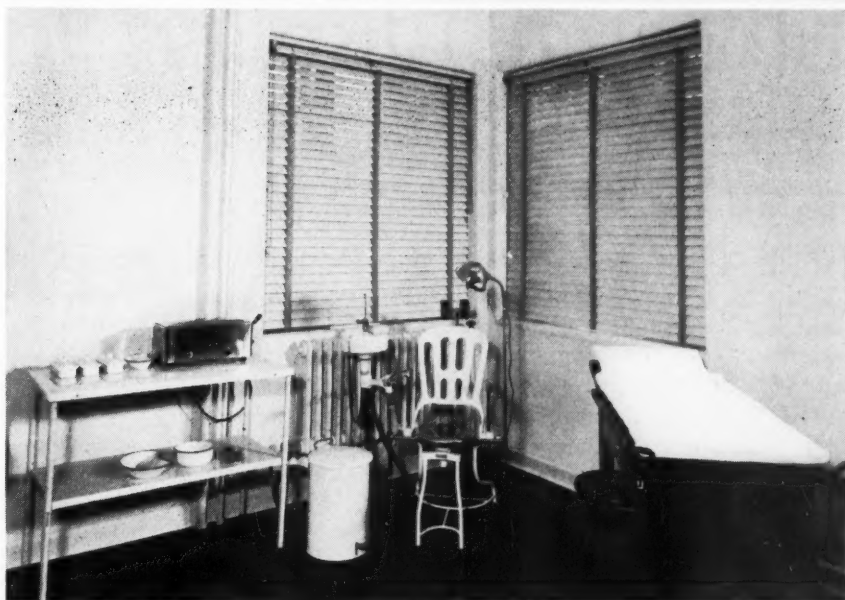
DEAN CONLEY

Business Manager

C. H. JOHNSTON

Architect, St. Paul.

Opposite Page: The second floor is similar in layout to the nursing unit below. It has a bed capacity of 29 because the section above the out-patient department is used for wards. The floor has a treatment room for minor surgery and the nurses' station is located to command the floor.



Above: A corner of the eye, ear, nose and throat room located on the first floor. In addition, there are two other examining rooms in this unit, as well as an x-ray room and the compact but well-equipped laboratory, which is shown at the bottom of the page. Left: Ambulatory patients have access to an attractive waiting room, which is furnished in modern oak with blue and yellow top leather upholstery.

KITCHEN: Electric food conveyor used to bring food from main kitchen in campus dining hall to floor diet kitchens.

X-RAY: 100 ma. combination diagnostic fluoroscopy unit.

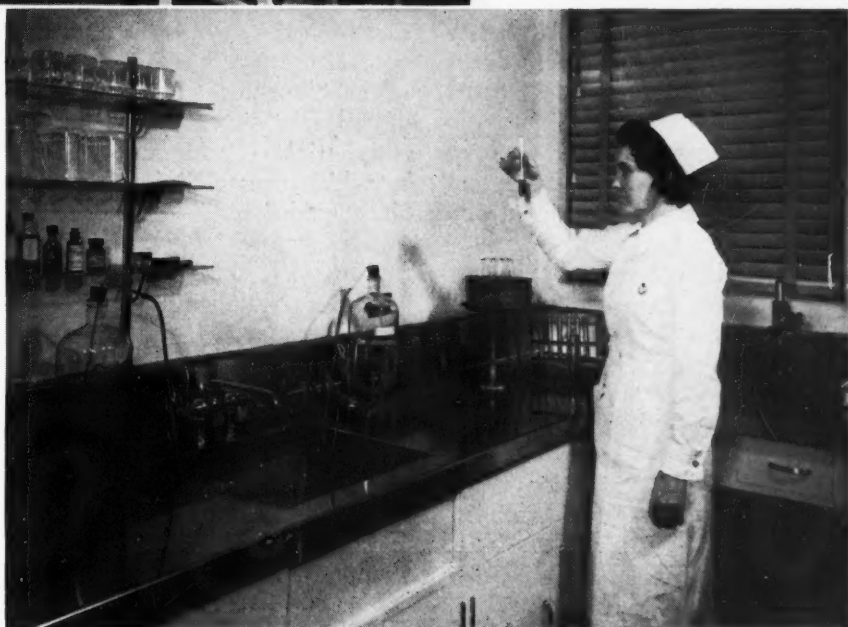
MISCELLANEOUS: Incinerator for disposal of refuse. Dish sterilizer for communicable disease cases.

COSTS:

Building	\$107,575.83
Tunnel connecting health service with dining hall, carrying water, sewage, heat, power lines	14,748.83
Equipment	10,220.18
Cost per bed (equipped)	3,398.58
Cost per cu. ft. (without equipment)56

FINANCING: General funds and P.W.A. grant.

CONSULTANTS: Pillsbury Engineering Company, Minneapolis.



Hospital Displays Its Wares

D. A. ENDRES

Superintendent, Youngstown Hospital Association
Youngstown, Ohio

THE functions and responsibilities of a large general hospital, including the operation of technical equipment for the diagnosis and treatment of disease, were explained to 8500 lay visitors during a four day exhibit at Youngstown Hospital, Youngstown, Ohio, in November.

The exhibit was held in the basement of the nurses' home where rec-

forms to illustrate the history of the nursing profession and the evolution of the modern nurse's uniform.

The visitors were treated to a surgical operation when the surgical service set up an operating room complete in all details and used a manikin to demonstrate the technic of an appendectomy. Two interns scrubbed and wore regulation surgi-



reational rooms afforded space. It included 33 displays and a small theater in which medical movies of popular interest were shown.

The exhibit was the outgrowth of a staff meeting held the year previous when the hospital department heads outlined the work of the institution to members of the lay boards of the hospital. The board members requested that a display be put on some time and the exhibit was arranged for them. It was thrown open to the public for three of the four days because of its general interest. Of the visitors, 1500 were senior high school pupils who were brought to the exhibit in small groups during the afternoons.

The pathology laboratory demonstrated the diagnosis of cancer by showing how sections of tissue are cut and stained for microscopic examination, while the biochemical laboratory gave away free "samples" by testing the visitors' blood for sugar and vitamin C.

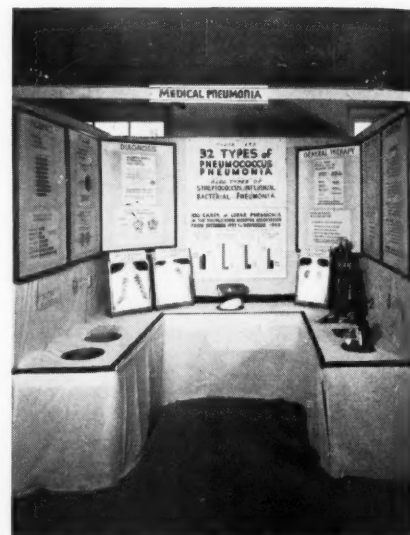
The training school dressed 30 dolls in various "habits" and uni-

cal caps, masks, gowns and gloves while performing the operation.

The physical therapy, orthopedic and vascular disease divisions had displays of equipment used in the treatment of patients in these classifications, while the obstetrical department illustrated how the cost of a visit from the stork is distributed in hospital charges.

The bronchoscopic clinic showed specimens of pins, coins, peanuts and other trinkets removed from the bronchial tubes of little tots. X-ray films, pathological specimens and casts were used by the divisions of neurosurgery, thoracic surgery and goiter surgery to illustrate the work of each group.

The medical service had four exhibits outlining the progress that has been made in the diagnosis and treatment of heart disease, diabetes, pneumonia and the anemias. The dietetic department cooperated in the medical displays and also illustrated the vitamin requirements of a normal diet in a separately housed exhibit. Ophthalmology, otolaryngology, proc-



Above: X-ray films show developments in the treatment of pneumonia. Left: Evolution of nurses' uniforms. Below: Dental exhibit.



tology, urology, dental surgery and industrial surgery and even the medical library of the hospital were represented by charts and diagrams.

The exhibit was planned by a committee of 20 persons who worked for almost eight months. Approximately 175 physicians, nurses, dietitians and other members of the hospital personnel took part in the preparation or explanation of the displays. The total cost of the exhibit was approximately \$250, which was spent for lumber and display signs. Most of the superstructure of the displays was erected by the maintenance staff.

Volunteers: Asset or Anathema

MADELEINE B. SCHILLER

Director of Volunteer Service
New York Post-Graduate Hospital

IN SOME hospitals a volunteer organization has a definite place in the scheme of things, while in others the very word "volunteer" is anathema to the hospital executives. The divergence of opinion with regard to voluntary workers is apparently the result of the varying quality of service rendered by these groups in different hospitals.

While we hold no brief for irresponsible, inefficient volunteers, a well-organized, well-disciplined and well-trained volunteer service can be of definite benefit to the institution. A discussion of the problems involved may be in order because, if the objectionable features of volunteer service were removed, all hospitals could have at their disposal a potential force for constructive effort.

Greater Problem in Big Cities

A hospital in a large city is confronted by more numerous and more discouraging volunteer problems, perhaps, than is a hospital in a small community. Individuals in small towns are more aware of their responsibility to their community. They regard their hospital with a proprietary interest; and the service they render as volunteers becomes a part not only of their daily routine but of their lives.

In a large city individuals seem to have less civic consciousness. There is a lack of unity of effort. There are more recreational pursuits to divert the volunteers' attention and occupy their time. Our first problem is to find a means of making the volunteers live up to their promises to give a specified amount of time to their work.

As a prerequisite, the volunteer organization must have a high standard of service. Each new volunteer should be impressed with the fact that she has a distinct responsibility in maintaining this standard and that she must recognize her obligation to attend the hospital regularly. Members of the group who are not dependable should be dropped. It is

well to have a rule that, should a volunteer be absent twice without notifying the hospital, her resignation will be requested. To facilitate supervision of the daily attendance, it has been found practical to include in the cross-file a set of index cards for each day of the week. The daily cards can be checked with the record of attendance which the volunteers sign each day.

Some volunteers are faithful in attendance when they are in town but take protracted trips. When signing up a new volunteer, it is advisable to establish whether or not she is of the nomadic type. Those who travel should never be assigned to service in a clinic. Each new volunteer must be instructed in the details of clinic work by a nurse or social worker. While these staff members consider it worth the time and effort involved to train someone who will remain and ultimately be of help, they are entirely too busy to train a new volunteer every few months.

Probably the only practical assignment for a volunteer who expects to travel is on a unit where the training is done by volunteers. This system is followed at New York Post-Graduate Hospital, New York City. An applicant for a volunteer position who expects to request a leave of absence is assigned to receptionist duty on the ward, private or semi-private floors. The volunteer captains conduct the training of this group.

The orientation program consists of a series of lectures based upon

"Spare the discipline and spoil the volunteer" is the maxim of Miss Schiller who explains how, under proper supervision, volunteer workers can be of real service to the institution

the volunteers' training manual, "Duties of Receptionists," compiled by the New York Post-Graduate Hospital. These duties are shown in the accompanying outline. The course is repeated every month, each one of the captains serving as instructor in turn.

Since many volunteers enroll for each class, there are always new ones available to replace those who have requested a leave of absence. The volunteer service continues to function normally and the staff is not subjected to any inconvenience.

Methods of Training

We have arrived quite naturally at our second problem, the training of volunteers. This is of great importance if efficiency is to be the keynote of the service. First of all, it is well to have a general lecture for all new volunteers, covering hospital ethics and describing the setup of a hospital and the relation of the different departments to one another. The diversity of the work in various clinics precludes the possibility of instructing clinic volunteers in their specific duties but a general lecture will provide them with a great deal of ground work.

In the social service department the work is highly specialized and we recommend that the director of volunteers should seek the cooperation of the director of social service in having members of her staff lecture to the group of volunteers engaged in social service work. These lectures need not be a preliminary to work in a clinic but should be attended by volunteers during the course of their service. It has been noted that instruction in connection with their duties stimulates the interest of all volunteers.

In training the receptionist the captains lecture in detail upon each of the topics listed in the manual. Every receptionist receives her own copy of the training manual, to which is appended a floor plan of the hospital together with a dietary department manual to aid her in the preparation of various types of nourishments for the patients.

If the assistance of volunteer receptionists is to be used to the utmost advantage, head nurses must know exactly what duties their volunteers are permitted to perform. At New York Post-Graduate Hospital the director of nursing provides the head nurse on each unit with a copy of the training manual.

At our hospital the director of volunteer service is also in charge of the patients' library. Her staff consists of the chairman of volunteer and library service, who is her first assistant and who knows how to coordinate the work of both departments; the vice chairman of volunteer service; the vice chairman of library service, and the captains in all departments.

We have described the rôle of the captains in connection with the training of receptionists. Their responsibility in the matter of enforcing discipline is equally important. Each captain exercises supervision over a certain number of volunteers and it is her duty to obtain reports of their work from the head nurses and social workers under whom they serve. These reports are submitted to the director of volunteer service.

The captains are constantly on the alert to see that no volunteer lets down the standard of service. They exercise conscientious supervision because they are keenly aware of their responsibility both to the hospital and to the volunteer organization. A volunteer group enjoys the confidence of the hospital authorities solely because hard working, efficient and faithful members have "sold" the idea of volunteer service to the institution.

Out of fairness to those who have worked hard to establish a reputation for efficiency and dependability, the captains will not permit the shortcomings of one or two irresponsible volunteers to destroy the result of their labors.

Organization within a volunteer system also provides a stimulus for constructive effort. An organization is built up by entrusting responsibilities to capable members of a group. This obviously entails a system of promotion, which has a salutary effect upon the quality of the work. When there is opportunity for advancement, based on efficient service, we find greater effort and more intense interest.

Duties of Receptionists

- 1. Telephone**
Making incoming and outgoing calls
Delivering telephone messages
- 2. Visitors**
Receiving and directing
- 3. Errands**
Obtaining supplies of all kinds
Delivering specimens to laboratories
Escorting patients for discharge and to roof
Sitting with patients on roof
- 4. Clerical**
Making lists and labels in ward routine
Making labels for specimens
Requisitioning laboratory supplies
Entering routine headings on charts
Entering routine admission and discharge notes
Reversing charts
Pasting laboratory and x-ray reports on charts
- 5. Supplies**
Rolling binders
Folding towels
Making special supplies
Folding paper bags and napkins
Preparing of P. O. table setup
- 6. Ward Routine**
Making lists and labels
Arranging flowers
- 7. Dietary**
Preparing refreshments
Carrying meal trays in and out

One of the most important considerations in a well-run volunteer system is maintaining discipline. In this connection the cooperation of the administration is indispensable. A certain measure of success may be attained by close supervision on the part of the director of volunteer service and her staff. But the cooperation of the superintendent of the hospital is necessary to guarantee the director of volunteer service complete authority in her own department.

A case in point is the "free lancing" of volunteers. In some hospitals doctors bring their own volunteers to clinic. These workers do not register with the director of volunteer service; in fact, she never sees them except by chance. They receive no manual. They do not know the rules of the hospital. Yet they are volunteers. Staff members do not realize that they are not connected with the organized group and frequently lose confidence in the entire volunteer

system which, they assume, these unaffiliated workers represent.

If a volunteer system embraces a "floating population" of workers who are in the organization but not of it, the director of volunteer service is certainly not in complete authority in her own department. This situation is decidedly detrimental to discipline. Not only is the director unable to control the unaffiliated volunteers but she loses prestige in the eyes of her own group. If she looks blank when one of her workers observes, "I see you have a new volunteer in medical clinic," that worker is going to be unfavorably impressed with the fact that the director does not know what is going on in her department.

The authority a volunteer director exercises over her group is based on the fact that she is a representative of the hospital. Her volunteers are dealing with the hospital through her. If the administration fails to cooperate with her, this amounts practically to a repudiation and seriously impairs her standing.

In order that the entire volunteer group may work in harmony with the staff, each volunteer should understand her relation to the hospital. A volunteer, not being on the staff, cannot be said to be a part of the hospital; yet her presence can aid in the smoother functioning of hospital work. By taking over routine duties that occupy much of the staff workers' time, she enables the nurses and social workers to devote more time to the patients.

Here, I should like to state that volunteers do not take employment away from paid workers. Hospitals are staffed in accordance with their requirements. The volunteers merely add to the speed and smoothness of hospital work by relieving the staff workers of routine details.

I have dealt at length with volunteer problems, particularly those concerning discipline. Now I should like to make the rather antithetical assertion that the matter of discipline need not constitute a problem at all. If the administration cooperates with the volunteer department and if the director of volunteer service and her staff instill in the members of the group a sense of loyalty to the hospital and the desire to strive for an ideal of service, the discipline will take care of itself.

Out-Patient Management

DEAN A. CLARK, M.D.
and
KATHERINE G. CLARK

A RECENT study of the organization of hospital out-patient departments and other clinics from the standpoint of the effectiveness of their service to patients indicated that all of the varying types of institutions have surprisingly similar opportunities and problems.

Fifteen clinics widely scattered through the East, South and Middle West were visited. As most of the visits were brief, this report makes no attempt to be statistical; however, some conclusions may be of interest.

Large clinics afford certain opportunities for specialized study and treatment of the patient that are not available in the office of every private practitioner. Similarly, certain problems arise in such organizations that do not exist in the individual physician's office. Among the latter are the following: (1) supervising the standards and coordinating the work of medical and associated technical workers; (2) providing arrangements that permit the development of a close and continuous relationship between patient and physician; (3) coordinating the findings of different departments, and (4) administering the project as a whole. Particular attention was given in this study to methods that have been developed to deal with such problems as these.

Out-patient service in the United States has increased not only in charitable and teaching clinics but in clinics set up by private individuals or industrial or cooperative organizations of workers and their families. Whether we call the professional work "group medical service" as at the Mayo Clinic or just "clinic service" as in the out-patient department of a nonprofit or a university hospital is not important. The essential relationships between physician and patient are substantially the same in all of these and, medically, they represent the same type of organization.

The authors are members of the Committee for the Study of Group Medical Practice, New York.



Out-patients awaiting their turn at Morton Hospital, Taunton, Mass.

Many different types of institutions were visited: four university clinics; three charitable general clinics; two private physicians' group clinics, which handle referred cases primarily; three private group clinics owned and controlled by the physicians themselves and furnishing general medical service on a periodic prepayment or insurance basis, and three cooperative groups furnishing similar service but owned and controlled by their subscriber members.

Most of the groups studied were encouraging a high standard of professional service by limiting the number of patients according to the number of physicians available. Limitation of attendance is practiced in private clinics of both fee and prepayment type and also in one cooperative association and in the university clinics. In all of these clinics patients are seen by appointment only, except in emergencies. Appointments are given on an hourly or half hourly schedule and all of the clinics are insistent that both doctors and patients keep appointments promptly. A strict appointment system eliminates the crowded waiting room and prevents unnecessary delays for patients and physicians. It also allows ample time for the consideration of each case. Flexibility in the schedule is obtained by leaving several appointments vacant every day for each of the doctors. There were complaints in certain clinics that patients have to make appointments too far in ad-

vance, but even in these instances there was general agreement that better medical care has been rendered since the appointment system was introduced.

In all the clinics visited medical standards were maintained and promoted principally by means of some degree of professional supervision. Such supervision was directed toward ensuring that the most effective use was made of the clinic facilities in the care of the individual patient, as well as toward overseeing the work of less experienced practitioners by more highly skilled physicians.

In several of the clinics, the physicians are given every encouragement to increase their competence in their special fields. This is accomplished partly through staff meetings, which are held monthly in all of the university groups and in most of the private and cooperative groups. Many of the clinics use funds to encourage original investigative work. Several of the private and university groups also allow their men to attend scientific meetings throughout the country on full salary.

Encouragement for advanced study is given at one cooperative clinic where at least one of the 11 physicians is sent annually, with full pay, to a recognized school for postgraduate study. The undesirable results of overspecialization are counteracted by several methods. In one large private group clinic, all the younger men are required to work for some

time in the general medical department, regardless of the specialty for which they are preparing.

In our series of visits we had opportunity to observe the working of both paid and unpaid clinic staffs. Where staffs were paid the remuneration of the physician was always based upon the ability and industry shown in his whole relationship with the clinic rather than upon the number of patients seen by him or upon the fees paid by his patients to the institution. Advancements in position or salary were usually proposed by the professional staff, subject to final action by those responsible for the financial affairs.

Little Financial Interest

In the universities and the larger reference clinics any advancement was found to depend largely upon the quality of investigative work done by the physician. In the smaller private and cooperative groups the chief consideration was the physician's ability, demonstrated in his daily work, to render a high type of medical service. As a result, physicians in both instances had little, if any, direct pecuniary interest in the patients but were chiefly concerned with developing superior standards.

In clinics of the university and charitable types, the original assignment to a physician is usually made by the lay admitting officer with no choice offered to the patient. Nevertheless, satisfactory and continuous physician-patient relationships are often achieved. For example, in the medical department of one large charitable clinic, reappointments are always made with the physician who sees the patient at the initial visit. Continuity is thus assured and it appeared from a study of 20 case records and from talking with several patients and physicians that excellent relations are usually developed.

On the other hand, improper application of the group principle may result in loss of the personal relationship between patient and physician. In the gynecology department of one large clinic, for example, apparently almost no opportunity existed for the patient to discuss her problems with a physician. One doctor took the history and another, with scarcely any comment to the patient, made the physical examination. Hence, the patient had to depend almost entirely

upon the social worker of the department for advice and instruction.

In one of the smaller private clinics, each patient is interviewed briefly on his first visit by one of the senior doctors. If the patient asks for a particular physician by name he is sent to him; otherwise, the patient is introduced to the physician considered best qualified medically and personally to handle the case. Usually, this is one of the general physicians of the group. An effort is made to distribute the patients equitably among the staff so that no physician will be overloaded. Inasmuch as the patients' fees are all paid to the group as a whole, there is no undesirable competition among the physicians to obtain the new cases. The patient continues to see the same physician at each visit to the clinic except when consultation or transfer is necessary for diagnosis or special treatment. If the patient wishes to change his doctor he is free to do it. Transfer of a patient from one staff member to another may also be made at the request of the physician in charge of the patient. A similar method is used in one of the large reference clinics.

Both doctors and patients interviewed at these two clinics felt that this method of selecting a physician works well. Patients do not seem to feel regimented and they believe that satisfaction with their doctor is enhanced by the fact that they are guided to select the most suitable man for their particular condition.

Whenever a patient needs to be studied or treated by several physicians, coordination of their work is highly important. Systematic methods for achieving this coordination were observed in all the clinics.

Thorough Examination Assured

In many clinics, patients may be admitted directly to a special department, just as in individual practice a patient may consult a specialist directly. Clinic organization, however, makes it possible to ensure that most such patients also receive a general medical examination. In one university clinic, for instance, any patient who has been seen as many as three times in a special division without a general examination is required to go to the medical department for such study. In the cardiac and syphilis departments of the same clinic, moreover, every patient is referred at least

once a year to the medical clinic for general examination.

The patients' ability to go to all necessary specialists without extra charge further facilitates consultation in the prepayment, private and cooperative clinics. One of the university clinics achieves much the same result by making no charge for consultations required for diagnostic purposes.

In one large reference clinic, a general physician is in continuous charge of the patient, even though a number of specialists may be called into consultation. The initial examination is made by this general physician who orders such laboratory tests and consultations with other physicians as seem necessary. Certain specialists are available for immediate consultation in the general physician's office. For extended examinations by others, the patient may be sent by appointment to the special departments.

General Physician Responsible

The general physician correlates all the reports and findings, explains and interprets these to the patient and arranges for whatever treatment is required. If hospitalization under the immediate care of another physician is necessary, the general physician remains in supervisory charge and the patient is discharged to his care. He makes the decision as to whether further clinic treatment is required or whether the patient may be dismissed. If the patient has been referred to one clinic by an outside physician, the general physician sends him a report of the clinic's findings and recommendations.

Of the 15 clinics covered by this study, five were owned and controlled by physicians and 10, by lay boards of trustees or other lay bodies. Whether the ultimate administrative control was in the hands of physicians, as, for example, in a private prepayment group, or of laymen, as in a nonprofit hospital or a cooperative clinic, seemed to have no appreciable effect upon administrative policies and procedures insofar as these affected the actual quality of medical care or the relations between physician and patient. In both physician owned and lay controlled clinics, physicians had immediate responsibility for all medical affairs, while lay persons were usually in charge of finance.

Can Students Govern Themselves?

RUTH SLEEPER, R.N.

Massachusetts General Hospital, Boston

THE thinking on the question of student government in nursing schools is confused. Administrators and directors of nursing both need to answer two questions before any adequate solution of the problem can be found. First, should we have a student government and, if so, why or, if not, why not? Second, if student government is not the best plan to meet our needs, what are we to choose?

Four Types of Government

Some time ago, Dean William F. Russell of Teachers College, Columbia University, classified the different types of government in four categories: (1) governments in which the ignorant lead the ignorant; (2) governments in which the ignorant lead the wise; (3) governments in which the wise lead the ignorant, and (4) governments in which the wise lead the wise.

Self-direction is possible only with intelligent understanding. Can we look for understanding in the immature student; can we look for growth in understanding without education or guidance? Can we look for effective progress by an organization of students whose immaturity and inexperience see only the most immediate goals and whose program is initiated too often by the self-interest of a few members?

If we are not to have a student government, what then? There are still two other forms. In one, the wise lead the ignorant, in the other the wise lead the wise. The first is a dictatorship or a benevolent autocracy; the second is a democracy based on the ideals of liberty, fraternity and equality. Our choice, like that of great countries today, must lie between a totalitarian and a democratic government, if maturity and experience are to guide. Here, again, there should be but one answer. If the student is to be prepared to live and work in a democratic community, should she not be prepared, through living and working

in a small unit of a democratic community, to see her place here and her obligations?

Government of the wise by the wise implies education of the students so that they may share as informed women in the regulation of their own living, and education of the faculty so that it may be wise in relation both to student needs and to the society in which the student must eventually live and work. This type of organization is based on respect for faculty as experienced and informed women and respect for students as younger women with similar experiences and problems to face. This type of organization implies and, properly used, should beget shared responsibility and cooperative effort.

Now to the question: "Why not participation through a student government?" I would answer: "Not through a student government but through a cooperative association which exists for government when government is necessary but which actually sets its goal beyond government and exists for the fullest development of the individual student."

Such an association will not produce results rapidly. It may sometimes reach its goal, but it will seldom, if ever, maintain the goal over a long period of time. The curve of its progress will have many low points and many plateaus. But if the student association is an educational activity, should we expect constant perfection? Do we not expect to begin anew with each group in the

classroom? Should we not expect to begin anew with each entering group in the student association?

Just what form the organization may take is not particularly important. The important factor is that both faculty and students be sufficiently informed to initiate and to carry on the project.

Actually, any faculty member, if she is well prepared for her teaching, is prepared to a degree for student organization work, for the work is education as well as recreation. If we examine the more common principles upon which we base our class preparation, we find the principles of exercise, effect, readiness, habit formation and integration.

From experience with student organizations, it seems to me that three different groups of principles are really involved: (1) the principles of teaching; (2) the principles of guidance, which help us understand student needs and modes of dealing with them, both individually and in groups, and (3) the principles of democracy on which the plans for the organization and its activities must be based if fullest development and happiness of the individual student are our goals.

Faculty Cannot Be Autocratic

It should be clear to faculty members that these principles of democracy do not exist for the student organization alone. A successful democratic student-faculty organization is highly improbable in a school in which the faculty and its activities are still on an autocratic basis. The teacher who is to guide student growth along the democratic way must first have opportunity to develop her own powers of self-direction adequately through shared participation in faculty projects.

Part of the information that students will need for participation in the cooperative association will be given best by direct instruction, not in classes but to small groups as, for example, instruction in parliamentary procedure, in keeping minutes, in keeping the treasurer's record, in budgeting the association income, in setting up and revising constitutions

Student government organizations in schools of nursing should be miniature democracies, Miss Sleeper contends, in which the students are prepared to live and work in a democratic community

From papers presented at the Illinois State Nurses' Association, 1940.

Definition of Self-Government

At a time when we need self-discipline and experience in self-discipline and in self-government, we find that many influences in modern life have left our young people unprepared for these high duties. The Freudian theory, much publicized and poorly understood, has been made to justify in the name of science the theory that restraint in any form is the root of all evils. The latter theory has crept into our educational system, has affected the curriculum and the technic of discipline in the classroom. It has crept into our family life in the management and discipline of children and at the same time there has been—what I cannot attempt to explain—a general feeling that nothing is too good for them; therefore, they must be given everything they desire.

Amusement and recreation come to our youths now with little effort on their part via the radio, the phonograph and the motion picture. Many of them have become physically lazy because of the automobile. Generally speaking, from childhood up they have been asked to take too little responsibility for the actual duties and management of the home. They are given too much and waited on too much in both home and school; the discipline of individual effort has been neglected.

Is it then to be wondered at that, when we try to put upon them the responsibility of student government, they are not ready for it? Student self-government is exactly what the term says. It is not a mere system with a few gifted, responsible young people doing all the work. It implies that each member of the system is doing her part in the governmental system. It implies honesty and trustworthiness, a willingness to live voluntarily according to the regulations set up by the group and sufficient belief in the value of self-government to be willing to sacrifice to make it work.

—Alice Lloyd, dean of women, University of Michigan, Ann Arbor.

and by-laws. Such instructions serve as tools to facilitate their group action and organization just as they facilitate our meetings in graduate organizations.

Other learnings are best taught indirectly and can be acquired through directed experience. These include ability to discuss in meeting, to select leaders, to support the leader elected, to see and meet personal obligations as members of the group, to work with others as members of a committee, to make reports and to enforce residence regulations assumed by the student association. By directed experience I mean committee meetings, larger association meetings or individual conferences at which the students share in the activities and responsibilities with a faculty member or members. Faculty members whose own experience has offered no opportunity to learn such procedures might obtain assistance from their alumnae associations. Students take real pride in records that are patterned after their alumnae association's records.

It will be recognized that this discussion is based on the assumption that there will be a school organization. Without one, participation may be possible to a degree, but it would, of necessity, be faculty-initiated. If the classes are organized, some participation can be planned through class groups. However, if in addition to class groups there is an organization representing the entire school, there will be opportunity for more students to participate, a broader range of activities, wider interests and less probability of forgotten minority interests.

If the school has no association, how should one be formed and what pattern should the organization take? We have often heard it said that the student should want an association before one can be established successfully.

This, I am sure, is quite true, for we should not have a student cooperative association if it must be imposed upon the student. But we do not wait for the student to desire other educational experiences before

we induct them into the lessons of the classroom. Moreover, when an organization is in existence, we do not expect each new student to signify her interest before admission is granted. It is not difficult to imagine the "subversive" activities arising from the problems of our young individualists if such were the situation.

Why, then, should we postpone this aspect of the student's education until she asks for it? Is it not our problem to find some activity that will produce the desired readiness? If students are gathered in committees to work with faculty members for social or recreational activities; if they are appointed on a committee for some social cause, such as the Red Cross; if they are directed in a big-sister plan, thereby sharing in a part of the orientation program for incoming students; if classes are stimulated to organize with a faculty adviser, or if a group of students who have already experienced a student organization is called together with a few others for discussion and planning by an enthusiastic faculty adviser, the plan will doubtless grow.

There must be a realization by both students and faculty, however, that progress may be slow; that there must be a two way understanding, *i.e.* the students must expect to give understanding as well as to get it; that the faculty must offer guidance, rather than dictation, and that the students must sense a sharing, not an unloading, of responsibilities. The beginning must needs be different in every different school situation. The particular organization pattern chosen is important only as it leads to the ultimate accomplishment of objectives.

Objectives should be appropriate, definite, easily understood and attainable with reasonable expenditure of time, energy and effort on the part of both student and faculty. The plan for reaching the objective should be simple enough for beginning students to grasp and flexible enough to allow changes as individual and group needs vary.

It may be difficult to plan objectives or to select a pattern or organization if neither faculty nor students have had previous experience. But there need be no concern when early plans are not satisfactory.

Changes in objectives and pattern that come when the group has given thoughtful consideration to its organization are healthy changes. They are not merely evidences of growth in the organization but evidences of growth in student-faculty understanding.

The objectives should, of course, state the real purpose of the association: whether it is merely to stimulate student activity, to plan social and recreational programs, to maintain happy and constructive conditions in the residence, to regulate student life in the residence or to stimulate student-faculty cooperation and understanding.

The working pattern or structure of the organization may be of the simplest type with the four regularly elected officers forming an executive committee which meets with faculty advisers for executive sessions. The meetings of the organization would be conducted by the student president but attended by both student body and faculty advisers. If the school is large, the number of students participating actively may be increased by adding to the executive committee the chairmen of standing committees, class presidents, class representatives elected by their respective classes and residence representatives elected by the members of their respective residences. Affiliating students present in the school might also send representatives. If the group becomes unwieldy, it may be divided. For example, one group may act as executive committee, while another is responsible for residence activities.

The more students there are participating actively, the greater will be the number of ways to stimulate interest and foster interpretation. A study of numerous associations in colleges and nursing schools shows patterns of organization ranging from the simplest one just described to complex patterns modeled on the plan of small civic governments with mayor, executive council and judiciary. Such a complex pattern would be practical only where many students were available for participation. Such a complex pattern, too, should evolve and not be thrust upon inexperienced faculty or students who are unprepared to understand the activities assigned to them. Students and faculty must decide

whether the cooperative association is to encompass and foster all school activities or whether there will be other separate organizations. They must also decide whether the association will have disciplinary functions in the residence and how far this authority will extend. In setting up both objectives and pattern, it will be wise to remember that few citizens enjoy acting as the police department except as its members sometimes share in recreational or other nondisciplinary civic activities. In other words, the association that places all or too large a proportion of its emphasis on enforcement of regulations and proctoring will not create the interest or obtain the participation that is possible in an organization where disciplinary functions are neutralized by normal social and recreational activities. The successful organization will be a kind of police force, school committee, park and playground commission, all in one.

Strange as it may seem, in the organization in which I am a faculty representative, the faculty members are often the ones who add the park and playground motif. I believe this is true because it is easier for us to see the total situation. We are more sensitive to boredom, to fatigue, to unrest of the group as a whole; we realize a little more readily the need for a little recreational livening. The

seniors of the group who might be more likely to sense the same needs are busy with class activities, year-book and senior prom and forget the intermediate student who is barred from all those exciting activities.

An organization for student participation is a difficult body to describe. It is composed of and exists for personalities. It can never be identical for two successive years, for its composition is never identical. Its success should be measured in terms not of organization achievement but of individual student growth.

Jan Struther, describing the son's return to school in "Mrs. Miniver," writes of the trip: "You died on the station platform, were reborn, not without pangs, in the train and emerged at the other end a different person with a different language, a different outlook and a different scale of values." Our students, too, experience this struggle. They come to us to be remade. Whether we shall guide them to independence, to the ability to live and work successfully with others, to be self-reliant and self-disciplined, to find enjoyment in simple and worth while recreation will depend upon our choice of activities and our success in obtaining participation. Upon us, also, will depend their ability to make the transition from successful participation in school to successful participation in graduate life.

St. Luke's Hospital Lists Its Needs

\$7500 will modernize and refurnish a ward for 30 patients. Several persons have thus "adopted" wards. Five of the wards in our older buildings are in need of kindly sponsors.

\$5000 will add a deep therapy x-ray machine to our equipment for the treatment of cancer. Two more are needed.

\$5000 will modernize and refurnish a ward for 20 children. Each of two wards is looking hopefully for "a friend."

\$2500 will redecorate and provide improved lighting for the St. Luke's originally beautiful chapel—a long-standing need that has had to be subordinated to the other requirements of the sick.

\$2000 will provide new quiet flooring and redecoration for a main traffic corridor.

\$1000 will buy the most approved operating table. Two are needed.

\$1000 will provide needed equipment and instruments for brain operations.

\$500 will aid one promising alumna of the

St. Luke's School of Nursing in pursuing a year's advanced study at Columbia University in preparation for a key nursing position in the hospital. Our work needs several such nurses.

\$500 will pay for enough heavy duty automatic toasters to supply hot fresh toast in a building for 140 ward patients. There are two such buildings.

\$240 will pay the necessary allowance for a year to a student apprentice to aid our librarian in extending the library service to all groups in the hospital.

\$200 will finance the care of two needy ward patients for the average length of stay.

\$50 would be a welcome addition to the loan fund for interns.

\$25 is the average rental charge for two medical educational films to aid in instructing the professional groups in training at the hospital.

—From St. Luke's Hospital Bulletin, New York City.

Hints on the Annual Report

MARGARET H. LYMAN

Assistant to the Director, New York University Clinic, New York

DOES your hospital publish an annual report? If so, what do you, as a hospital trustee, know about the report? Do you read it each year as it comes out? Do you find it interesting? Does it tell you important facts about the hospital's work? Have you ever inquired of your colleagues and acquaintances what they think of the report? Do you feel that your hospital's report would interest people in giving money to the hospital?

To a busy trustee (and most trustees are men or women of many affairs) these matters may seem relatively unimportant and not worthy of a trustee's concern. Perhaps in your hospital the trustees authorize expenditures for the annual report automatically and then wash their hands of the matter, leaving to the superintendent the task of working out as best he can the problem of planning and executing the report.

Perhaps, on the other hand, there is considerable discussion as to whether a report should be published and, when the money is finally voted for it, the funds are inadequate to carry out the ideas and plans of the superintendent. Perhaps, also, the lay board of your hospital has its own ideas as to the makeup and content of the report and insists upon uniformity of reports year in and year out.

How Important Is It?

Whatever the special circumstances, it would seem worth while at this time to raise the question of the function of the hospital report and its importance in the hospital field. In this connection it may be of interest to examine briefly the content of a group of typical hospital reports. The group in question comprises 20 recent reports of general and special hospitals in and around New York City. These reports cover a total of 1416 printed pages, with individual bulletins ranging from 15 to 201 pages each.

Sixty per cent of the total pages (by actual count) comprise full page tables of statistics and lists of donors and staff. This is a conservative figure as statistical tables combined with text were not counted. Three reports have neither graphics nor pictures; six others show only buildings. Of a total of 136 pictures (including covers) a third are of buildings or hospital personnel. The majority of the 91 photographs of hospital activities are contained in only six reports. Only four reports have less than 45 per cent of the space devoted to statistical tables, lists of staff and donors and pictures of buildings. In seven reports more than 70 per cent of the space is devoted to this material.

To whom do these reports go? To trustees, donors, staff, officers of other hospitals and social agencies, prospective donors, important members of the community. Do the majority of these people like to read page after page of unexplained statistics? Do they understand them? Do present donors and estates continue to give just because their names appear in the hospital yearly bulletin?

Is it of fundamental value to the professional staff and the institution to print lists of the resident staff dating back to the year one? Does any of this material give the average reader a clear idea of the hospital's policy, its work, what it costs and what it needs? If this kind of copy were presented to you by your business advertising counselor, would you accept it?

Perhaps it has never occurred to you to think of your hospital as a business. To be sure, it is a different type of business from that of producing and marketing the commodities and other services with which we are familiar in everyday life. The modern hospital, with its staff of experts in many fields and its elaborate

equipment, is none the less a business which creates and sells to the community a fundamental service—medical care. The fact that the hospital, as a rule, does not sell at a profit makes it even more important that money spent for any purpose whatsoever be spent intelligently with a view to the highest possible return in quality of service, good will, gifts or public use.

Public Should Know Facts

We are told that we spend \$1,500,000 a day for hospital pay rolls and that \$1,000,000,000 is spent each year for maintenance. If the public is to bear its fair share of this expense it must first be allowed to learn about hospitals. Other businesses spend hundreds of millions of dollars a year telling the public about their services and the commodities they sell. Hospital care is a complicated service even to the initiated. The general public knows little and understands less about the policies and organization of hospitals, the various services they offer, the fees and the cost of care and the reasons behind all these things.

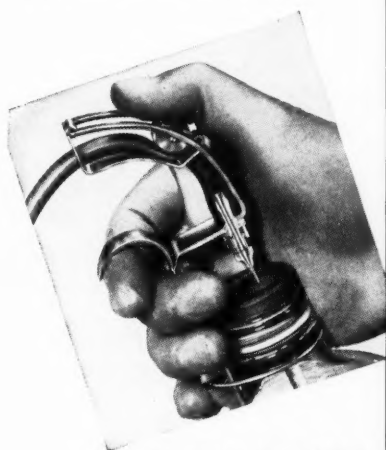
The hospital annual report can be a useful and important instrument of public relations if it is properly planned and executed for that purpose. Too much money is now being wasted on dead material. This is not necessarily the fault of the hospital superintendent. A superintendent's excellent ideas for an interesting report may be blocked completely because the lay board is unwilling to spend the money.

Moreover, it should be recognized that most superintendents need the help of a publicity expert in presenting technical material for the layman's interest and understanding. In other businesses general managers, superintendents and presidents are not expected to produce advertising

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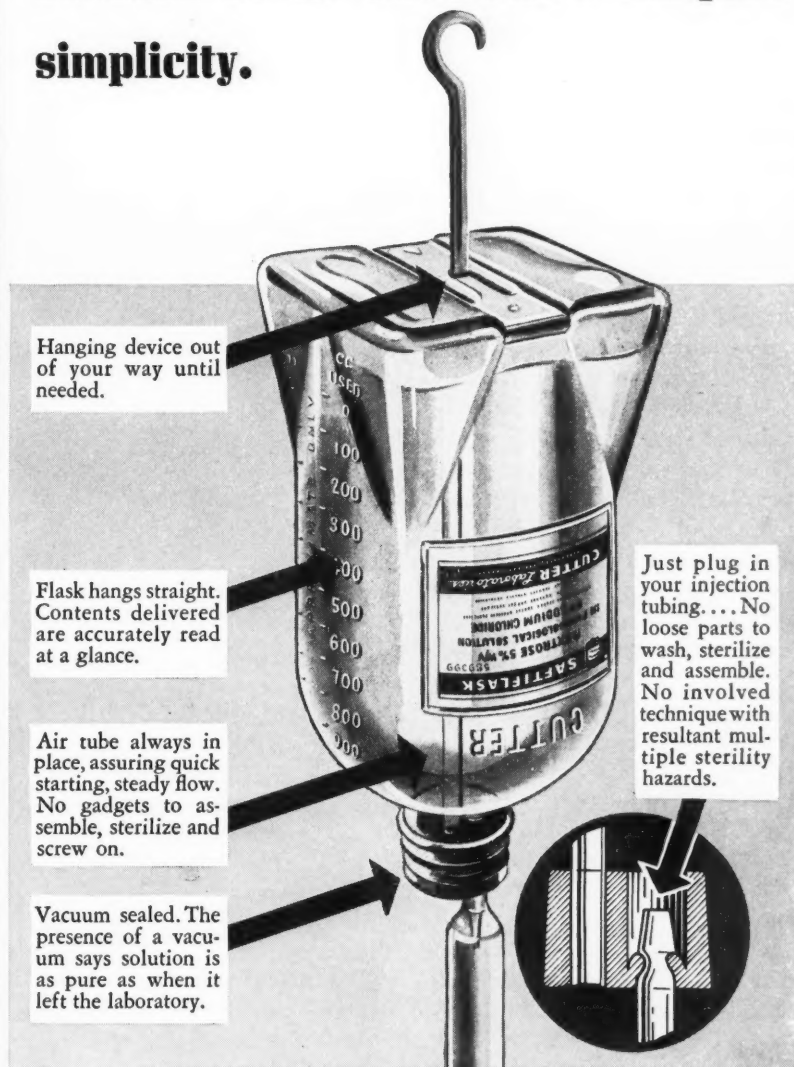
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copy. If there is an advertising man on your lay board he will recognize this fact. He might even arrange to help in planning the report.

Many hospital bulletins, according to our study, devote page after page to medical statistics, donors lists and financial and operating statistics. Hospital superintendents are often afraid to omit or change these sections without their trustees' approval. Medical statistics, as such, have no place in a layman's report. As for lists of donors, it would be worth while to find out how important they really are.

Facts about money gifts could be shown briefly and in a much more interesting fashion by simple graphics. As for financial and operating statistics, they must be condensed and presented in clear, simple and dramatic form for the layman. The public needs to understand about hospital costs and the volume and type of work done, but this subject matter will never "get across" in the form of solid pages of unexplained figures.

When this year's bulletin comes up for discussion by the lay board, why not find out what kind of a publication your superintendent has in mind? Examine recent bulletins from your own and other hospitals. A few hospitals are trying new experiments and you will find attractive and interesting bulletins from some of these institutions. Has your own hospital been wasting money, \$400, \$500, \$1000 or more each year, printing dead material? How much more would it cost to dramatize your story? What would be gained by dramatizing it?

Among the first changes your superintendent will want to make will be the addition of photographs of hospital activities. This will cost money but if the subjects are intelligently selected and skillfully taken the money will not be wasted. Everyone enjoys vivid photographs. They help greatly to enliven your bulletin and they can be cropped and used in a different way another year.

Friends in the community and paying patients are as important to your hospital as the donors. If your annual report is to be distributed in the community it ought to be definitely planned to make friends for the hospital. This means telling the highly technical story of the institu-

tion and its work in such a clear, simple and dramatic way that people are bound to be interested and will want to know more. The story must be told so as to make prospective patients feel that they really know something about your hospital and have sufficient confidence in its service to want to use it. Money spent for the services of a good publicity man to assist the hospital superintendent with his bulletin is not wasted, if your annual bulletin makes friends for your hospital.

On the other hand, the superintendent of your hospital or someone on his staff may be equipped to plan and write a satisfactory bulletin himself. Even so, he still needs your support and backing and the necessary funds to complete the project.

The total outlay necessary to produce an effective bulletin depends upon the general plan of the publication: the length, the number of photographs, the amount of tabular

material and text, inclusion of graphics, the type of cover, the size of the booklet and the quality of paper. The unit cost, of course, varies with the quantity ordered.

It may be of interest here to quote some of the items entering into the cost of printing 1000 copies of the 25 page bulletin of New York University Clinic. The photographs, taken by a skilled professional who knew about the clinic and was interested in it, cost \$10 each. The halftone plate for the cover cost \$15; unillustrated text, \$7 a page; text with photograph, \$11 a page; staff lists, \$10 a page, and tabular material, \$12 a page.

It is interesting to note that the statistical data and lists cost more to print than straight text and that the statistics cost more than text with photographs. Consultation service on the layout and the drawing of two graphics cost \$50. The total cost of the report was approximately \$521.

How Trustees Can Help

CHARLES O. PAULY

Managing Director, Lutheran Hospital, New York City

IT IS not necessary for trustees to be familiar with medical or surgical terms, procedure or technic, or with the many ramifications and details of the inside operations of a hospital. Such knowledge, while it is helpful, is not necessary, so why would it not be better for them to delve into the capital structure, physical plant needs, housing of nurses, building of good will through various channels of publicity, community health needs and raising necessary funds to permit the management to expand the services of the hospital.

It should be the accepted responsibility of every hospital trustee to see that a substantial building and the right kind of equipment are provided to render the best service.

The trustee should be interested in the financial structure of the institution and should see to it that operating capital is available to meet deficits accruing from charitable services rendered to the sick poor.

He should exploit his trusteeship to friends and acquaintances by telling them of the hospital's needs for which he is trying to provide and

which, if met, would bring the blessings of good health to many.

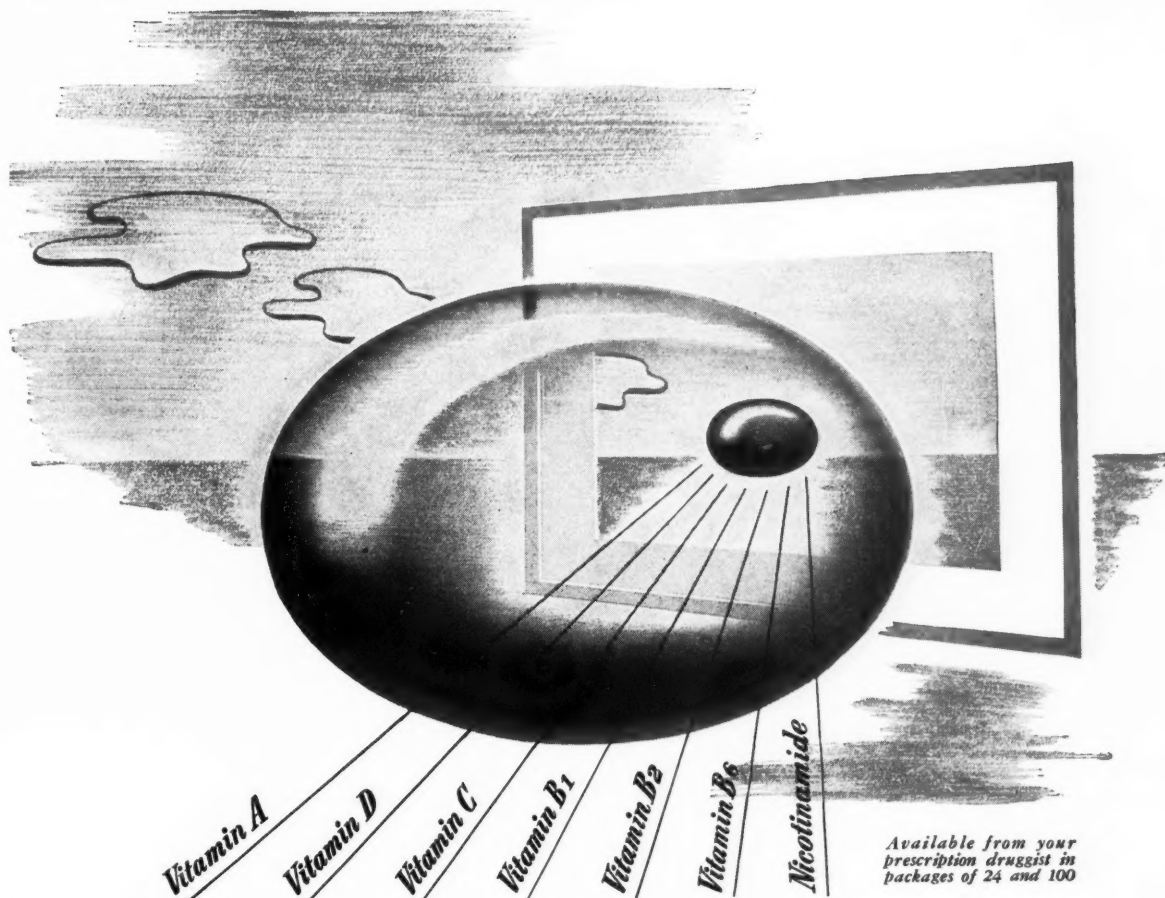
He should solicit annual memberships and talk legacies to attorneys who prepare wills for clients and who are frequently asked for suggestions as to worthy objects of charitable bequests.

As a trustee he should know that the income from patients cannot be expected to pay for operating costs, plant maintenance or new equipment or to provide for up-to-date surgical equipment to keep abreast of improved technics as they are developed in research laboratories.

With this knowledge, the functions and responsibility of trusteeship become a matter of acceptance and the desire to accomplish. The rest is really only a matter of application.

If we put more emphasis on directors who understand and accept their responsibilities and less on the present lack of philanthropy, economic conditions, government ownership and control and other alibis, our hospitals will not only survive but succeed.

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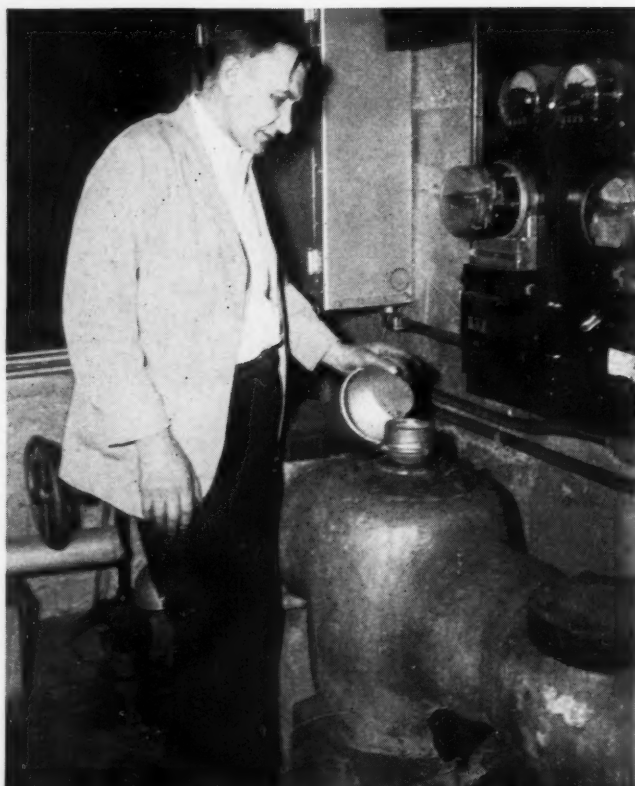
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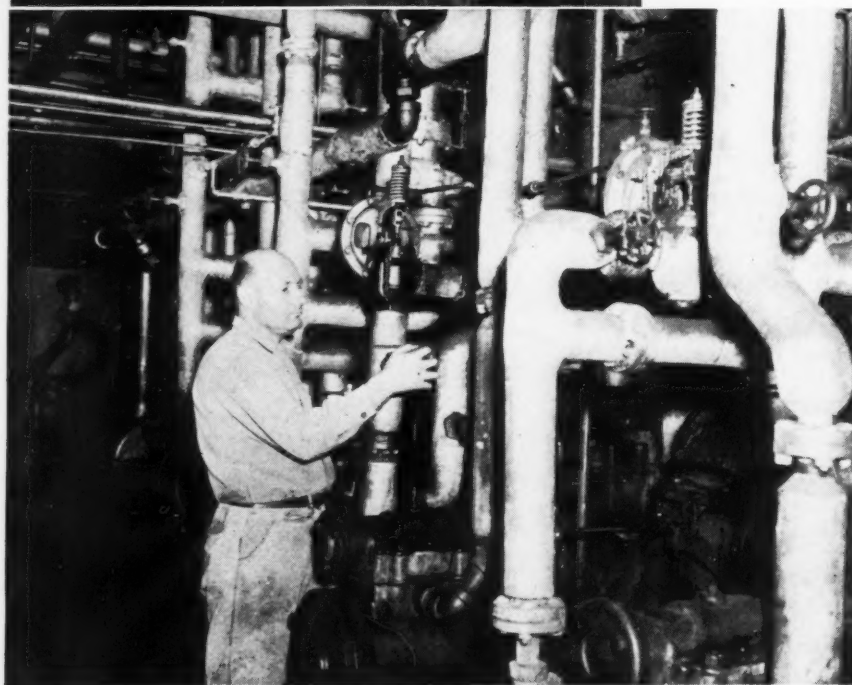
Savings With a Water Softener

L. D. REID and HERMAN HENSEL

Auditor and Assistant Administrator, Respectively
Presbyterian Hospital, Chicago



Left: Soft water has cut costs in the boiler room. The chief engineer checks the meter at the supply line. Below: One of the assistant engineers opens a valve in the process of regenerating the softening mineral with salt. The water softener tank is in the background.



THE softness of rain water has long been recognized as the reason for its effectiveness as a cleaning agent and within recent years science has found that water from other sources can be made to approximate the softness of rain water by the removal of certain elements known as "grains of hardness."

The water softening system in use at Presbyterian Hospital, Chicago, removes calcium and other elements by sending the water upward through a mineral bed. In time the mineral loses its effectiveness but, instead of being discarded, it is regenerated by means of salt and its usefulness is restored.

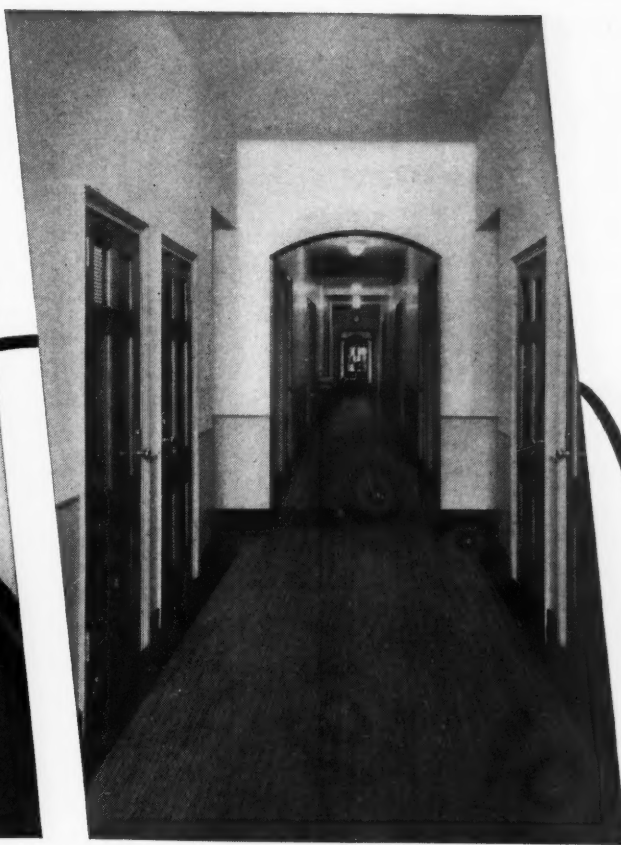
The laundry department of any hospital uses an enormous amount of water. At Presbyterian Hospital numerous savings have been effected since the installation of the water softening system.

Of primary importance was the saving of \$1430.82 in washing soaps and powders during the first year. In addition, we have found that the time required to complete a wash load has been reduced from sixty-nine to fifty-two minutes, a decrease of 24.6 per cent. This decrease in washing time is due to the elimination of a number of rinses which are no longer necessary because of the greater effectiveness of the water. This means further savings in the cost of water, as well as longer life for the linens because the increased speed and ease of washing reduce the "wash wear."

Since the washing time has been reduced, we have found it possible to handle increased poundage to the extent of 14 additional wash loads in a week's operating schedule of forty-eight hours, without any additional equipment. Stated another way, by cutting down the operating time we automatically increase the length of life of our washing equipment before the ordinary wear and tear of usage begins to affect its performance. One important result of the use of



Note interesting cove-base treatment in this corridor of the Hackensack Hospital, Hackensack, N. J. It makes cleaning easier, assures complete sanitation. This particular installation is 17 years old, and still going strong . . . proof of the permanency of Nairn Linoleum Floors.



This corridor in the State Mental Hospital, Howard, R. I., is "quietized" for the life of the building itself. For Nairn Linoleum gives long years of satisfactory service. Border at junction of floor and wall increases the attractiveness of this installation.

THE PATIENT SAYS: *"They're quieter"*
THE STAFF SAYS: *"They're easier to walk on"*
THE BUDGET SAYS: *"They're economical"*

TO YOUR PATIENTS . . . Nairn Linoleum Floors offer a new degree of comfort, because of the quietizing qualities which reduce noise and clatter to a minimum.

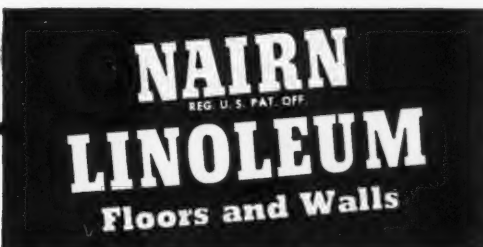
TO YOUR STAFF . . . the footease of this resilient material brings comfort, plus increased working efficiency.

TO HOSPITAL AUTHORITIES . . . Nairn Linoleum's

low first cost and minimum maintenance mean that they can get the most modern, most practical hospital floor material *at a price within the budget.*

Nairn Floors are attractive, too. Completely sanitary, because the super-smooth surface is so easy to clean. When installed by Authorized Contractors, Nairn Linoleum is fully guaranteed.

CONGOLEUM-NAIRN INC., KEARNY, N. J.



soft water is the appearance of the linens. They are softer and whiter, a factor that has added appreciably to the comfort and satisfaction of the patients.

Soaps and powders are essential in keeping halls, rooms, china and glassware clean and shining. In the housekeeping and dietary departments, an immediate saving of \$607.89 in supplies was shown the first year. This amounted to a reduction of 39 per cent in the annual

Right: Dishwashing machines operate better with softened water.



Above: The laundry reports lower costs and longer life for linens.

cost of these items. As so much less soap is necessary with the soft water, we carried on an educational program among the employees to demonstrate that the same work could be accomplished with fewer supplies.

This was not the only saving made, however, for a monthly maintenance cost has been eliminated in the dietary department. Formerly, each of the seven dishwashing machines had to be cleaned with an acid solution every month in order to remove the scale which had collected. This meant loss of time while the machines were out of service, in addition to the time required by the maintenance department to do the work. Now the operating performances of the dishwashing machines are more uniform because no scale accumulates to reduce the efficiency.

One of the jobs of the maintenance department is to keep the boilers and

heaters in efficient working condition; here definite savings have been made in supplies, time and labor. Before the installation of the water softening equipment we spent approximately \$350 a year for the purchase of boiler compound and acid to remove the scale that collected in the boilers. Inasmuch as soft water does not form a scale, this expenditure has been eliminated. Furthermore, the periodic cleaning of the boiler tubes meant that each boiler had to be shut down for twelve days; moreover, the full time of two men was required for eight hours each day. With three boilers this meant the loss of seventy-two days' labor over a period of a year plus approximately ten days that were required to clean the heaters.

Stated in terms of money value,

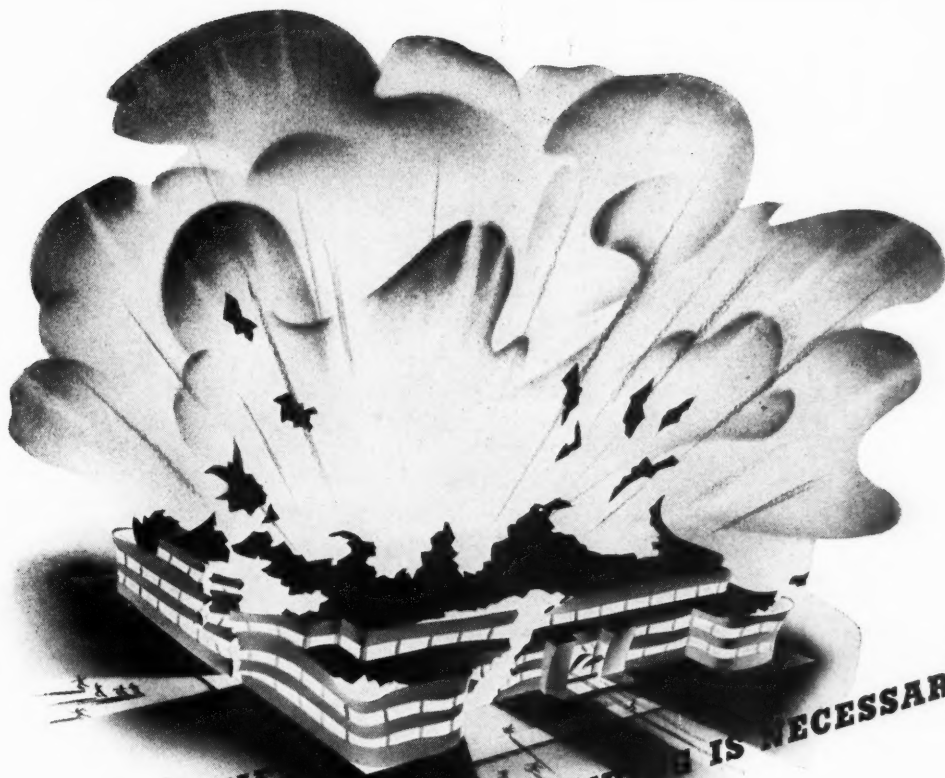
it cost us from \$400 to \$425 each year to clean the boilers. These days of labor saved mean that we now have men available to do all of the other odd jobs that come along.

One of the most important advantages of the new system, from the operating standpoint, is that our boilers work at a uniform degree of efficiency rather than with decreasing efficiency as is the case when hard water scale is forming from day to day.

The savings effected in the various departments of the hospital may be summarized as follows:

Laundry	\$1430.82
Housekeeping and dietary	607.89
Maintenance	350.00
Total	\$2388.71
Salt necessary to regenerate mineral	975.00
Net saving	\$1413.71

The net saving of \$1413.71 does not include other savings made in the laundry department which could not be reduced to dollars and cents; nor is the labor involved in cleaning out boiler tubes and heaters included. Nevertheless, on the basis of a 5 per cent return on our investment, we would have been justified in spending \$28,274.20 to install the system; actually, it cost us less than one fourth this amount. It is anticipated, as a result of our first year's experience, that the original cost will be repaid in less than five years in savings on supplies alone.



*** PLASMA FOR EMERGENCIES NO TYPE IS NECESSARY!**

PLASMA & SERUM

prepared with BAXTER EQUIPMENT

If your community is engaged in defense work, you will want information in regard to establishing a plasma and serum bank. Plasma and serum can be prepared with maximum economy using the SIMPLE, SAFE AND COMPLETELY CLOSED Baxter vacuum equipment. Blood is drawn from donor into a Baxter Centri-Vac for sedimentation or centrifugation. The plasma or serum is then aspirated into a Baxter Plasma-Vac for dispensing, storing, or for transporting—SEALED IN VACUUM. Write for Booklet "PSB"

**SERUM ALSO*



THE BAXTER CENTRI-VAC AND PLASMA-VAC

Products of
BAXTER LABORATORIES
 Glenview, Ill.; College Point, N.Y.; Glendale, Cal.; Toronto, Canada; London, England
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 Eleven Western States by **DON BAXTER, INC.**, Glendale, Cal.
 Distributed East of the Rockies by
AMERICAN HOSPITAL SUPPLY CORPORATION
 CHICAGO NEW YORK

Safe Handling of Ether

SOME hospitals are adopting the practice of purchasing anesthetic ether in large containers and the small containers used in the operating room are filled from the large ones. Unless proper precautions are exercised and adequate safeguards are provided, such handling of ether may present a serious fire and explosion hazard.

As a result of long experience with the use of ether as an anesthetic and widespread knowledge of safe practice in its administration, hospital operating room staffs are generally aware of the hazards involved in operating room use, but the filling of small containers from larger containers presents a somewhat different hazard that may not be fully appreciated.

Ether is a highly flammable liquid that vaporizes readily at all ordinary atmospheric temperatures. The vapors form flammable or explosive mixtures with air in proportions ranging from 1.85 per cent to 36.5 per cent ether to air by volume.

This means that a mixture leaner than 1.85 per cent ether in 98.15 per cent air cannot be exploded; that mixtures in proportions from 1.85 per cent ether to 36.5 per cent ether can be ignited and will burn or explode depending on the exact proportions, and that a mixture richer than 36.5 per cent ether in 63.5 per cent air can be ignited only if additional air is supplied for combustion. The vapor from $\frac{1}{4}$ lb. ether will make 60 cubic feet of air explosive.

The ignition temperature of ether is approximately 356° F., which means that if any portion of a flammable mixture of ether and air is heated to this temperature it will ignite and flame will propagate throughout the flammable mixture, producing either fire or explosion in accordance with the characteristics of the mixture. Ignition may occur from contact of the vapors with flame, a static or frictional spark or any heated object which is at or above the ignition temperature.

The vapors of ether are approximately two and one half times as heavy as air, as a result of which

they tend to settle in low spots and, although gradually mixing with air, they will remain in such low spots for a considerable time if not affected by drafts. Such heavy vapors will flow in a stream along a floor or down stairs and upon reaching a source of ignition will propagate flame back to the source even from considerable distances.

The filling of containers with ether should preferably be done in a small isolated building so that any fire or explosion that might occur would not endanger the lives of patients or of employees in the hospital proper.

In a building used for any other purpose, the containers should be

Safeguards against explosions and fires resulting from improper handling of ether are recommended by the National Board of Fire Underwriters

filled in a special room of fireproof construction. Partition walls forming such rooms should be of reinforced concrete at least 4 inches thick, or of brick at least 4 inches thick or of hollow clay tile at least 6 inches thick or of solid or cored gypsum block at least 4 inches thick; partitions of brick or block construction should be plastered on both sides with not less than $\frac{1}{2}$ inch of cement or gypsum plaster.

Floors and ceilings of such rooms should be of reinforced concrete at least 4 inches thick or of other construction that is noncombustible and equivalent to it in fire resistance. The room should be an outside room with ample window area of thin glass to serve as a vent in case of a vapor explosion, and the windows should face in a direction presenting the least exposure to other buildings.

Any door opening between the room and other parts of the building should be protected with a standard self-closing fire door. This should

be kept closed at all times and a tight noncombustible sill at least 6 inches high should be provided to guard against flow of vapors or liquid into other parts of the building.

Adequate ventilation of rooms in which containers are filled with ether is most important as reasonable safety can be attained only if vapors are prevented from accumulating at any point in the room. As ether vapors are heavier than air, ventilation should be arranged to remove air from near the floor. Window openings and other arrangements depending on natural ventilation may not be effective when needed most.

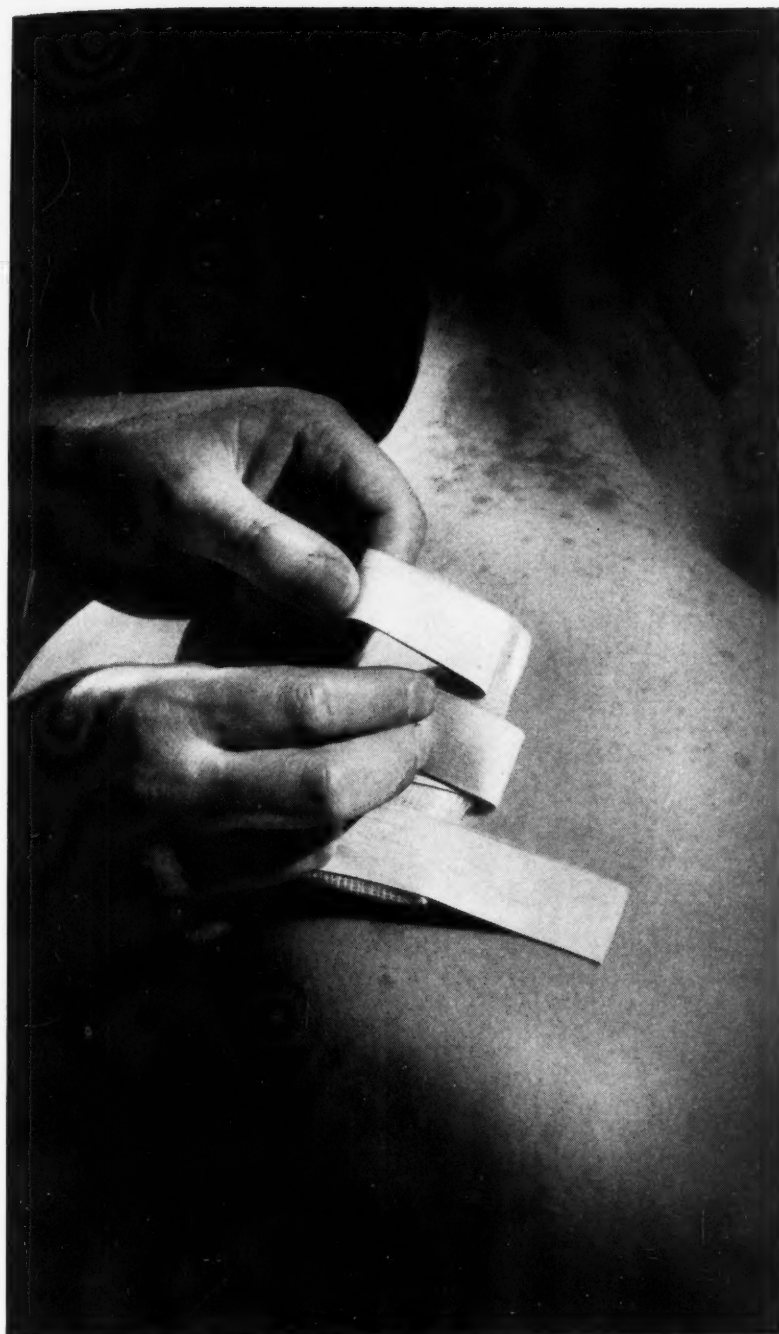
To remove vapors adequately either an exhaust fan should be installed in an outside wall and arranged to draw air from near the floor or an exhaust system should be installed with ducts drawing air from one or more points near the floor as well as directly at the points where vapors are most likely to be given off. In either case the fan should be of nonsparking type and the motor driving it should be explosionproof.

All electrical equipment in the room, including lights, switches, motors and wiring, should be of a type approved for use in hazardous locations of class I, group C, which is the only type of equipment that is safe for use in atmospheres containing ether vapor.

Containers should be filled through closed piping or tubing systems if possible so as to avoid unnecessary discharge of ether vapors. The liquid should preferably be removed from the large containers by pumps so as to avoid accidental discharge of liquid onto the floor.

In order to provide protection against the hazard of static electricity all equipment should be adequately grounded.

In view of the necessity for these safeguards it may be more economical to purchase ether in small containers. Storage of ether in small sealed containers presents little hazard if they are kept in a cool place, apart from combustible materials and sources of ignition.



Lessened Irritation

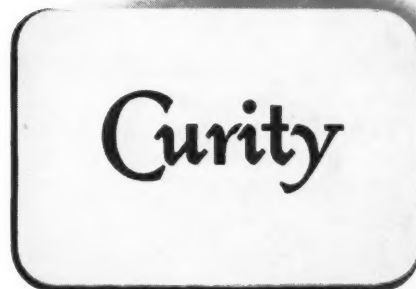
CURITY ADHESIVE

Hypo-Lergix made with Formula 87

●For more than a year, wide-spread clinical experience has confirmed the advantages of the improved Curity Adhesive, Hypo-Lergix made with Formula 87. It is markedly less irritating than any former Curity adhesives, reducing the incidence of skin irritation to a negligible percentage. And the adhesive mass has improved ageing qualities—even after long storage or exposure to adverse conditions of heat and dryness, Curity Adhesive remains tacky (sticks quickly) and adhesive (stays firmly in position). Hypo-Lergix made with Formula 87 is also used in Curity Adhesive Ties, the first ready-made adhesive dressing for hospitals.

Now, more than ever before, Curity can be of service to you—the recent consolidation of Lewis Manufacturing Company and Bauer & Black has united the vast research and manufacturing facilities of two great organizations to service your dressings and suture needs efficiently, economically. Let your Curity representative acquaint you soon with the new Curity program.

LEWIS MANUFACTURING CO • BAUER & BLACK
2500 South Dearborn Street, Chicago
DIVISIONS OF THE KENDALL COMPANY



RESEARCH TO IMPROVE TECHNIC, REDUCE COSTS

Practical Food Purchasing

MARGUERITE RICHARDS

Executive Dietitian
Fairmont Hospital, San Leandro, Calif.

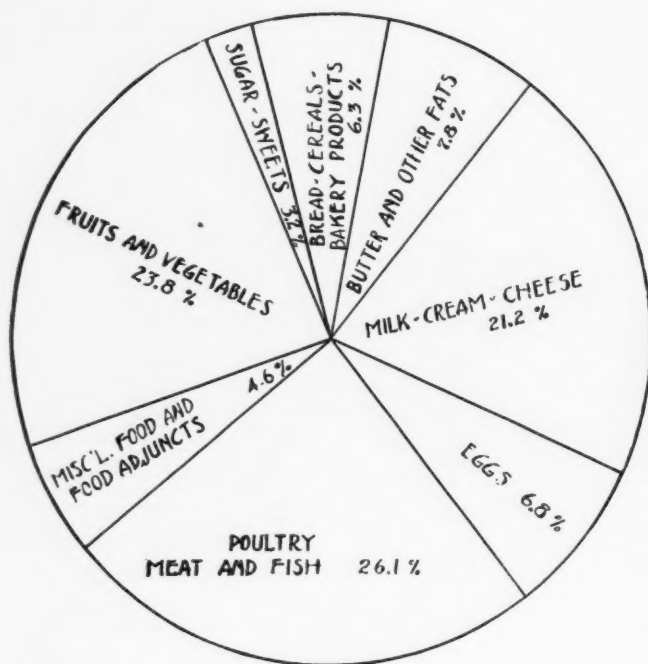


Chart showing how the food dollar was spent at Fairmont Hospital in 1939. Dairy products accounted for nearly a third of the amount, with meat, fish and poultry running a close second.

FROM 25 to 33 per cent of the maintenance budget in hospitals is used by the dietary department for the purchase of food. Therefore, in the interests of good management and economy, it is extremely important that the purchase of food be well controlled and efficiently handled.

The purchase of food for the hospital is affected by many factors:

1. *Type of Institution:* Purchasing procedures vary according to whether the hospital is government owned, i.e. federal, state and county, or voluntary.

2. *Location:* If the institution is far from market centers, the problem will be somewhat different as delivery service, time and accessibility to the market must be considered.

3. *Sectional Food Habits.* In the Middle West, the prevailing types of meats are beef and pork. Lamb and mutton are not preferred. On the West Coast, a patient often is satisfied with a couple of broiled lamb chops when other suggestions have failed.

Presented at Western Institute for Hospital Administrators, 1940.

4. *Average Number of Meals Served Daily:* Better prices can be obtained when large quantities of food are purchased. Therefore, prices paid for some food items by a small hospital will be greater than those paid by a large one.

5. *Donations of Food:* Such foods must be taken into account and used. This may be a major factor in localities in which payment of hospital bills is made partially with commodities rather than cash.

6. *Facilities for Storage:* If storage space is limited, future purchases will be curtailed.

Economical buying must be supplemented by proper storage of food stuffs in order to ensure a minimum loss through spoilage. Fresh fruits and vegetables must have a refrigeration unit sufficiently large to permit circulation of air between crates and boxes. If only one unit is available, a temperature between 32° and 40° F. and a humidity from 80 to 90 per cent are best. Milk, butter and eggs require a refrigeration of their own between 38° and 40° F. For central storage the "walk-in" type of refrigerator with shelves is

best. Smaller utility refrigerator units or ice boxes should also be provided. Meat, fish and poultry keep best when the temperature is between 32° and 34° F. with a humidity between 70 and 85 per cent. No other foods should be stored in the milk or meat ice boxes.

Bread and bakery goods are usually bought or made daily, so storage can be made on racks in a small room or closet off the bake shop. Groceries may be stored at ordinary room temperature between 70° and 80° F. It is best to buy cereals often and to keep them in tight containers or easily cleaned places to prevent vermin. They must be inspected often. Coffee retains its flavor longer if it is delivered in the bean and ground just before using. Coffee deliveries should be made weekly or oftener if it is necessary to buy ground coffee.

Circular 278 of the U. S. Department of Agriculture, entitled "The Commercial Storage of Fruits, Vegetables and Florists' Stocks," by D. H. Rose, R. C. Wright and T. M. Whiteman offers a comprehensive discussion of the subject of temperature and humidity requirements.

In government owned institutions, the purchasing of food is done by a central purchasing agent. In voluntary hospitals, it may be done by a central purchasing agent or by the dietitian. Some of the advantages of a purchasing agent are:

1. The responsibility is placed in hands of a specialist who is presumably trained in this field.

2. Buying, especially of staple articles and canned goods, can be done for several institutions at the same time, thereby effecting a considerable saving.

3. Definite purchase procedures can be inaugurated and followed.

APPETIZERS FOR EVERY TASTE



An international achievement are these assorted hors d'ouvres—tuna and salmon from Alaskan waters, sardines from Portugal, caviar from Russia, anchovies from the Mediterranean. Domestic touches are the California artichokes, the shrimp from the Gulf Coast and the pickled salad from Sexton's own Sunshine Kitchens. The Sexton assortment of sea food assures pleasure to the most exacting taste—and a complete selection of appetizers for your service.

SEXTON

QUALITY FOODS

1883

CHICAGO • DALLAS • BROOKLYN

ADVANCES IN CANNING TECHNOLOGY

II. Development of the Tin Container

● Appert, discoverer of canning, did not know the reasons why his procedure for food preservation was successful. He clearly recognized, however, that his containers must be so constructed and sealed as to prevent contact of the food therein with air, after heat processing. Today we know that this is necessary to prevent re-infection of the food with air-borne, spoilage micro-organisms.

As containers, Appert suggested glass containers sealed by corks; the reason given is that glass is the "matter most impenetrable by air" (1). In 1810, one year after Appert's discovery was announced, Peter Durand, an Englishman, patented a procedure very similar to Appert's, which covered the use of a variety of containers, among them "vessels of tin (tin-plated iron)." From that time forward, the use of tin-plated containers rapidly progressed.

Commercial canning began in America about 1819. In 1825, Kensett and Daggett, two pioneers of canning in this country, received an American patent covering the use of tin-plated containers. Shortly thereafter, the name "tin can" was coined from the abbreviation of the formal name, "tin cannisters."

The story of the development of the tin can in America is an absorbing one which has been related in more detail elsewhere (2, 3, 4). By the time of the war between the States, the "hole and cap" type of can had been evolved. About 1890, can-making machinery was introduced to replace the

older hand-manufacturing operations whereby a skilled artisan could produce about 6 cans per hour. Modern can-manufacturing lines operate at speeds as high as 350 cans per minute.

The first three decades of the current century witnessed the development of machinery to make the modern type or "sanitary style" can now universally used for fruits, vegetables, and a wide variety of other products. The past ten years have brought vast improvements in the tin plate from which cans are made. Not long ago, almost any type of sheet steel was considered satisfactory. Today plate for cans must comply with rigid physical and chemical specifications established by the Research Laboratory of the can manufacturer.

As far as can be determined, tin containers were first introduced to avoid breakage which was experienced with the glass containers proposed by Appert. The other desirable characters of the tin container for foods were not fully appreciated at first; among these advantages should be mentioned its rapid rate of heat transfer, its low weight in relation to its capacity, and its opacity to light. Nor was the importance which the tin can has attained in our national life fully appreciated until world developments caused America to pause and take inventory. Only then was it generally realized that from its humble start 130 years ago, the tin can has risen to become an indispensable article in our modern civilization.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

REFERENCES

- | | |
|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| (1) 1811. The Art of Preserving. M. Appert, Black, Parry and Kinsbury, London. | (3) 1937. Appertizing. A. W. Bitting, The Trade Pressroom, San Francisco. |
| (2) 1937. The Canning Clan. E. C. May, The Macmillan Co., New York. | (4) 1940. The National Geographic Magazine, November, p. 659. |

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-eighth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

4. Standards of quality are controlled and products are more uniform. Definite food specifications can be adhered to more rigidly.

5. Dietitians are relieved of the mechanics of the work and are able to concentrate on other duties.

The advantages of having the dietitian purchase food are:

1. The dietitian knows more about the quality of the foods required.

2. She knows more about the amounts that should or should not be purchased and the advisability of buying futures. For example, in one institution the dietitian was not consulted concerning the buying and such enormous quantities of a certain kind of jam were purchased that, to the dissatisfaction of everybody, the supply lasted for five years.

3. The dietitian can keep up better on market trends and thereby plan her menus and purchasing to a greater financial advantage.

4. Emergency shortages are difficult to fill if there is too much "red tape" to go through.

5. The dietitian is interested in operating her department economically inasmuch as she is held responsible by the superintendent for food storages, complaints and the cost of operating her department.

Dietitian Should Keep Records

While detailed records of bills and payments thereof are made by the accounting department of the hospital, the dietitian must keep appropriate simple records of food estimates, purchases and costs. She should be able to keep her administrator informed of food costs and operating expenses of her department and should discuss them with him. A written financial report indicating how the money for the food has been spent should be rendered to him at intervals.

The accompanying table shows the form used at Fairmont Hospital, San Leandro, Calif. It is divided into food costs and operating costs, such as miscellaneous, expenses and salaries. Food costs are broken down into subdivisions of major food groups: dairy products, meats, fruits and vegetables, bread and rolls. Columns showing weights and costs for the month and the previous month allow a comparison of food costs and amounts used. Further down

on the report the total number of meals served is compared with the figure for the past month and for the same period of the previous year. The value of such a report is that it not only tells you where you stand financially in the culinary department but serves as a comparative basis for investigation when increase or decrease of costs occurs.

Price trends, market conditions and seasonal changes must be watched when planning menus. Comparison of costs of fresh and canned foods per serving must be made to determine which is more economical in relation to the type of service desired in the institution, considering food and satiety values of each. Apples at \$2 a box are not as advantageous from a price standpoint as peaches at 75 cents a box. In serving 500 persons, there will be a \$2 difference in the total cost. Fresh apples, dried prunes and apricots are used almost exclusively in some charitable institutions. These could be as cheaply supplemented at certain seasons with such fruits as oranges, fresh apricots, peaches and pears.

Portion costs can be calculated by weights and a knowledge of loss in preparing and cooking food items. String beans at 6 cents a pound are cheaper, with a loss of only 8 per cent in preparation and 3 per cent in cooking, than is asparagus at 3 cents a pound, with a loss of 37 per cent in preparation and 10 per cent in cooking. In other words, the string beans will cost about 1 cent a serving while asparagus will cost 2 cents a serving.

In buying meats a certain amount of fat on the back and ribs of the animal is one of the indications of good quality of meat. Excessive fat, however, is uneconomical because the dietitian is anticipating a certain number of servings of edible portion of lean meat per pound.

Institutional equipment has a relationship to purchasing of food. For example, when buying for a large hospital where an electric potato peeler is used a smooth-skinned potato of uniform size is less wasteful than one with knobs and indentations. For hand peeling, the latter type is just as satisfactory and may be much more economical. If labor is an item in some institutions, frozen foods are as economical as

fresh foods except when fresh foods are in season locally.

In any institution in which the dietitian does not do the buying, it is most important, yes, even imperative, that she keep in close contact with the purchasing department, making known her wants with regard to quality and quantity and checking to see that no radical changes are made without her knowledge. Her menu should be sufficiently flexible that she can take advantage of such "quick buys" as the purchasing department feels advisable because of savings effected.

The three general methods of food purchasing are: (1) the bid system; (2) direct purchasing through salesmen and producers, and (3) a combination of the two, whereby all non-perishable and semiperishable goods, such as canned goods, flour, sugar and coffee, are bought on bids, while perishable goods, *i.e.* fresh fruits and vegetables, are bought on the open market or from producers.

Competitive Buying Advisable

The general opinion of buyers throughout the country seems to indicate that competitive buying properly handled results in obtaining the best quality of merchandise at the lowest prices over a long period of time. The Veterans' Administration hospitals use the bid system and have standard written specifications for various types of food. These may be obtained by writing to Dr. Charles Griffith, medical director, Veterans' Administration, Washington, D. C.

Most foods for the state institutions in California, with the exception of those produced on their own farms, are also bought on definite specifications which indicate the quality of the merchandise. In Alameda County such items as meats, milk, eggs and butter are bought on bids by written specifications; others, such as coffee, tea, jellies, jams and canned goods, are bought on bids by samples submitted and tested. Fresh fruits and vegetables are bought on the open market.

The disadvantage of the straight bid system lies in the fact that so much red tape is involved that the dietitian has to work too far ahead. While in some instances advantage may be taken of a rising market, the best prices are not usually obtained since bidders have to protect them-

Financial Report of Culinary Department

	June 1940		May 1940	
	Weights	Costs	Weights	Costs
FOOD COSTS				
Dairy products: butter, cheese, milk, cream, eggs.....				
Fruits and vegetables.....				
Meat, fish and poultry.....				
Bread and rolls.....				
Cereals and pastes: rice, macaroni, flour.....				
Jelly, jams, marmalade.....				
Coffee.....				
Sugar.....				
Groceries.....				
Total cost of food.....				
MISCELLANEOUS EXPENSES				
Gas for fuel.....				
Dishes.....				
Cleaning supplies.....				
Repairs and replacements.....				
Total.....				
TOTAL SALARIES				
TOTAL EXPENDITURES OF DEPARTMENT				
	June 1940	May 1940	June 1939	
CREDITS				
Grease and cracklings.....				
Garbage.....				
Meals sold.....				
TOTAL OPERATING COST				
MEALS SERVED BY DEPARTMENT				
Patients.....				
Employees.....				
Visitors.....				
Residents.....				
Total.....				
COST OF FOOD PER MEAL				
COST OF PREPARING EACH MEAL				
TOTAL COST OF EACH MEAL				
COST OF FOOD PER DIEM				
TOTAL COST PER DIEM				
FOOD61.2% of total cost of operating department			
LABOR and MISCELLANEOUS38.8% of total cost of operating department			

selves against market changes, in quoting several days ahead of delivery, and advantage cannot be taken of prevailing market conditions on the day of delivery.

In making food purchases under the bid system, definite specifications should be adhered to rigidly. There are general specifications that can be applied to all foods in a certain class. For example, "foods must be of the best grade prepared in accordance with best commercial practices and under strictly sanitary conditions," and "all deliveries must conform in every respect to the provisions of the latest Food and Drug Act." These should be followed by specific specifications for each type of food.

A suggested outline of specifications for purchasing canned fruits and vegetables published in May 1938 and prepared by Paul M. Williams, senior marketing specialist, may be obtained from the bureau of agricultural economics, U. S. Department of Agriculture. The buyer should be familiar with the pure food and drug law and any city and

state laws regarding practices in the sale of raw and manufactured foods. He should be familiar, also, with various grades and classes of foods, not only of canned goods but of all types of food commodities, in order to make the most satisfactory and economical purchases. Copies of grades may be obtained from the bureau of agricultural economics.

Mary deGarmo Bryan, Teachers College, Columbia University, has published the second edition of her book entitled "The School Cafeteria." This should be most helpful to anyone interested in food service and buying. She has devoted almost half of the book to food purchasing and tables of food specifications.

Another good book for the buyer is "Food Buying and Our Markets" by Monroe, Kyrk and Stone, published by M. Barrows and Company, New York, 1938. Alexander Todoroff has written a book in question and answer form called "Food Buying Today." It is published by the Grocery Trade Publishing House, 755 North Central Avenue, Chicago.

Many of the state agricultural colleges have extension circulars available on buying foods. Household Finance Corporation, 919 North Michigan Avenue, Chicago, publishes "Better Buymanship" booklets that list the various classes of food stuffs.

I should like to recommend the following rules to be used when buying foods:

1. Purchase from reliable dealers only.

2. Consider competitive bids because they encourage the dealers to check quality and price.

3. Purchase fresh fruits and vegetables that are in season; off season foods not only are expensive but usually do not have as good flavor.

4. Buy directly from the canner in year lots if possible.

5. Buy in as large a quantity as can be used economically.

6. Buy fresh fruits and vegetables by weight instead of measure whenever possible.

7. Do not always buy the best, but purchase for a specific purpose. For example, topless carrots sold by the pound are just as good for soups and stews and are much cheaper than bunch carrots. Margarine will work usually better in icings than butter and is much less expensive.

8. Avoid fruits and vegetables that show decay and distinguish between blemishes that affect the appearance and those that affect the eating quality.

9. Make personal selection of fresh fruits and vegetables. Telephone orders do not enable the purchaser to select the most satisfactory products.

10. Reduce cost of delivery by sending a truck to collect the food if it can be spared by the institution.

11. Purchase "off sizes" in fruits and vegetables when use permits. For example, large avocados may be less expensive and as satisfactory in certain salads as the more popular smaller size.

12. Check for quality, weight and other information on labels of all canned and packaged goods.

13. Inspect all foods upon arrival and store immediately in proper places so that no spoilage will occur.

14. Make experimental studies in your own institution of the types, sizes and grades of food that are most satisfactory and at the same time are economical.

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EDISON-HOTPOINT OVENS

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ROASTING, scalloping and au gratin work are only a few of the oven cooking jobs that these Edison All-Purpose Ovens do to speed up and lighten meal-time preparations. Scores of leading hospitals have specified Edison Ovens because baking and roasting, as well as general cooking operations, may be carried on in them with superior results, for each section has directional and automatic heat control. Many dishes formerly prepared on wasteful range tops may now be prepared better and more economically in these insulated, automatic All-Purpose Ovens. The savings in shrinkage, in spoilage, and in labor are great. Not to mention the added cleanliness and comfort they bring to your kitchen! Edison General Electric Appliance Co., Inc., 5662 West Taylor Street, Chicago, Illinois.

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Selecting Silverware

CLARE SCULKY

Assistant Dietitian, Roosevelt Hospital, New York City

SILVERWARE should at all times be associated with good service and good food. In order to set up satisfactory specifications, the purchaser should understand thoroughly the characteristics of the various standards of commercial silverware and should also know the important operations in the manufacture of silver plate.

Silverware has an interesting background. The rounded tips on our dinner knives, for instance, have a historical reason for being. Cardinal Richelieu, a most fastidious gentleman, was disgusted when one of his guests used the point of his knife as a toothpick and directed his steward next day to round the ends of his entire collection of knives.

In ancient times, the fork was used as a weapon and was associated with mythological characters. It was used for holding food over fire and then later appeared on the table. In Italy during the sixteenth century the guests, principally of the nobility, brought their own silverware and, therefore, the hosts did not have to worry about table service.

Nickel Silver Is Base

Nickel silver is used as the base metal for plated wear rather than lead silver plate, formerly known as German silver. Although both are composed primarily of copper, nickel and zinc, the quality is governed by the amount of nickel in the mixture. Eighteen per cent nickel silver is used for hollow ware and flatware. It is composed of 18 per cent nickel, 67 per cent copper and 14 per cent zinc.

Blanks are cut out of stock, graded and rolled until they are the corresponding size of spoons or forks. They are then placed in various presses and the spoon bowl and fork tines are shaped out and struck with the pattern dye. The item is cleaned, polished and prepared for plating. This process is accomplished by electrolysis. The article to be plated is hung in a solution and silver is deposited on it, the thickness of silver

depending on the length of time the article stays in solution. Sometimes, an extra plating of solid silver is given on the area of wear as an overlay.

The various accepted standards of commercial silverware are as follows:

Weight of Blank: 10½ lb. weight means 10½ lb. per gross of teaspoons; 9 lb. weight means 9 lb. per gross of teaspoons.

Amount of Solid Silver in All Overlay: Half standard plate means 1 oz. per gross of teaspoons; 2 oz. on full standard plate means 2 oz. per gross of teaspoons or 4 oz. on tablespoons. Triple plate means 6 oz. per gross of teaspoons or 12 oz. on tablespoons; quadruple plate means 8 oz. per gross of teaspoons or 16 oz. on tablespoons. When comparing prices it must be ascertained whether the number of ounces of silver refers to teaspoons or to tablespoons.

When it is considered that from 60 to 70 per cent of the cost represents a labor charge, it is evident that a good repair job costs almost as much as new merchandise. The manufacturer should make repairs because the local repair man may not be able to obtain the original parts.

Silver has many distinct advantages over other metals. It has a distinctive color, does not feel slippery or greasy, combines well chemically with foods and does not retain tastes or odors as do other metals.

Other metals have certain disadvantages. Nickel silver turns dark with use and feels greasy; chromium plate has a blue cast and grows dark; aluminum is too light and feels cheap, and stainless steel feels greasy and is difficult to clean.

Stainless steel will not corrode, however, and if it is properly constructed it will not dent or bend in ordinary wear and will not wear off. It is particularly desirable when unusual durability is needed, as in state institutions and in industrial cafeterias. The newest patterns in stainless steel flatware are attractive, with dull finished handles and highly polished bowls, tines and blades.

In buying silverware, one should keep in mind the following points:

1. Select good silver and appropriate patterns.
2. Avoid items with sharp corners. Look for rounded bottoms in coffee pots and creamers.
3. Examine the insulation of the handles of articles to be used for hot liquids.
4. Short spouts are preferable to long spouts because they clean easily.
5. Be sure the thickness or gauge of the base metal is ample to ensure the required strength.

Backs Get Hardest Usage

6. The backs of spoons require more silver plating than the front because they are subject to the hardest wear. Authorities say that 60 per cent of the silver, before the second and final plating is applied, should be on the back of the spoon.

7. Plate must be uniform, that is, one piece must receive as much silver as the next. Modern automatic machinery has eliminated most variations.

8. The overlay or second plating of solid silver on bowls and tines must be balanced to the all-over plate. The thinner the all-over deposits of silver, the thicker in proportion must be the overlay. The overlay is important because it pays dividends in service. Buyers should specify overlay by size and number of ounces per gross in the all-over plate, as well as in the overlay.

9. The pieces should feel substantial but not clumsy. They should have good balance in the hand. As an example, if a heavy metal is used in the blade, in comparison to the handle, the blade may be shortened and the handle lengthened in order to produce good balance.

10. The pieces should be stiff enough to resist bending. Try bending the fork not only at the shank but also at the tines.

11. The finish should have a deep silvery luster and the edges should be carefully polished especially between the fork tines and on the edges of the hollow-handle knives.

12. There should be no small holes. (Look at the backs of the pieces.)

13. If the knives have hollow handles the blade must fit accurately. Is all the excess solder removed care-

ONE OF THE *Biggest Little Things* IN MODERN NUTRITION



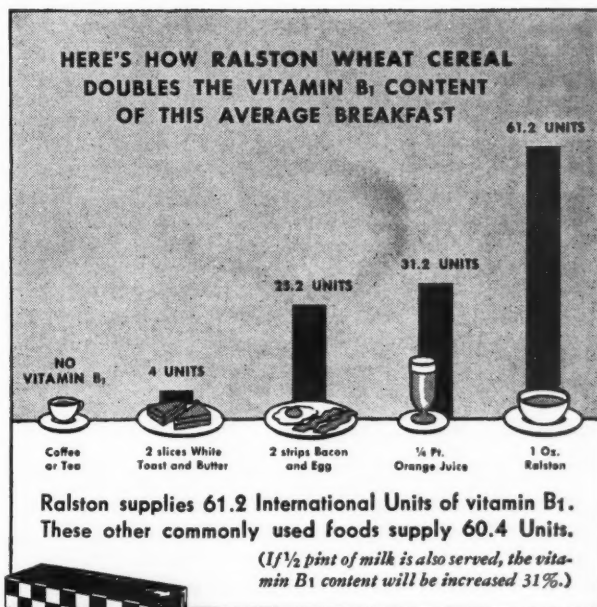
The tiny wheat germ, one of Nature's richest sources of vitamin B₁, is one of the biggest little things in helping to protect against vitamin B₁ (thiamin) subnutrition in modern diets.

Take breakfast, for example. The accompanying chart shows how Ralston, enriched with natural wheat germ, doubles the vitamin B₁ content of the average breakfast. Each ounce serving supplies 61.2 International Units of vitamin B₁—considerably more than whole wheat itself, much more than most other wheat cereals.

For this reason many hospital dietitians specify Ralston regularly—depend on this delicious hot cereal to help increase vitamin B₁ content in patient and staff diets.

Purchasing agents and superintendents welcome its use also because Ralston is economical—three servings cost only a penny—and it is easy to prepare, cooks completely in 5 minutes.

FREE TO HOSPITALS: New illustrated 20-page bound book, "Whole Wheat and Its Importance as a Source of Natural Vitamin B₁," and generous supply of samples sent free on request. Send name, title and hospital. Address Ralston Purina Company, 939C Checkerboard Square, St. Louis, Mo. (Offer limited to United States.)



Ralston

puts the B₁ in Breakfast

fully? The presence of excess solder is detected by close inspection which discloses a roughness that is not existent where the plating covers the base metal of the knife.

14. A pattern should be selected that is attractive but simple in design so that it can be easily cleaned. Any ornamentation should be clear cut in order to reduce both the cost and labor.

A blank of 18 per cent nickel silver of not less than 9 lb. per gross of

teaspoons should be specified. Full standard plate plus overlay is desirable if finances permit, although a half standard plate plus overlay will give many years of satisfactory service.

In purchasing silverware certain definite specifications should be included in the order: the total number of ounces per gross that the teaspoons will strip; the number of ounces per gross in the all-over plate; the number of ounces per gross thick in the

overlay, and the size of the overlay.

Silverware is all too often abused by careless employees. Some of the commonest abuses are: (1) grinding the edges of flatware by using it to scrape utensils; (2) improper cleaning and use of coarse abrasives; (3) allowing the silver to tarnish blue-black; (4) careless handling, which causes dents and nicks and bends pieces out of shape, and (5) overheating, which causes damage to hollow ware near trimmings on soft soldered parts. Hard usage plays havoc with patterns on which there is too fine or delicate ornamentation.

New patterns in institutional silverware have developed slowly in the last ten years. The simpler the design the more popular it is.

Many pieces have been developed that are compact and take up little space. Combination dishes or plates have been designed to serve several purposes. Combination bowls are used covered as well as uncovered. The addition of a ring or tripod makes them attractive for fruits and fish cocktails. There is also a combination bowl that can be used for cocktails and for orange and grapefruit juices.

Shapes of hollow ware have changed little. Institutions prefer oval to oblong shapes, which are more expensive because of the complicated spinning process.

Spoons no longer have insanitary dirt collecting crevices. Bodies are seamless, corners are rounded for easy cleaning and the simplicity of lines gives grace, beauty, richness and durability.

A knife, known as the viande knife, is a fairly new development. It has a short blade and long handle to facilitate cutting. A short blade cuts as well as a long blade. Bolsterless knives are more popular as the ridge next to the blade is entirely eliminated.

The interchangeable card holder and napkin ring fills a long felt need in hospital and institutional service.

Spouts are shorter in coffee and teapots to facilitate cleaning. Ends of handles that cover the insulation are now split to eliminate bands, thereby improving the appearance of the article. The pots are rounded inside to facilitate cleaning.

The stub tine fork is a new development and its principal characteristic is stability at the tines.

Food Clinic in the South

SALLY ANN KURKA

Nutritionist, American Red Cross, Roanoke, Va.

IT IS important in a community in which incomes are low that there be some institution where people can receive medical, dental and nutritional aid at minimum cost. In Roanoke, Va., the Burrell Memorial Hospital performs these services for the benefit of colored people of the community.

In October 1939, a nutrition clinic was organized by the nutritionist of the Roanoke County chapter of the American Red Cross. As a start the nutritionist was available at two medical and two prenatal clinics each month. The prenatal clinic is always well attended.

At the first prenatal clinic, 18 women were present. The nutritionist talked to the group about proper low cost diets during pregnancy. The next week the same procedure was followed with a new group of women. Because these women were interested in hearing more about foods, they returned the following week and the nutritionist told them something about food elements, illustrating the lecture with charts and pictures.

Some of the women were not obstetrical patients but were interested in learning more about nutrition; particularly, about losing weight. These were talked to individually, their caloric needs determined and safe reducing diets worked out for them. Follow-up visits or telephone calls were made, with the result that each one lost some weight.

When one woman's friends say, "Oh, you are on a reducing diet," she

answers, "No, I am just eating correctly." One "patient" in particular lost 12 pounds in a period of seven weeks.

The school nurse brought seven underweight children to the clinic, where each had a physical examination and was then put on a weight gaining diet. Every one of them gained from one to five pounds within a short time after they were put on the diet. A form sheet similar to the one used at Johns Hopkins was used to keep the records of the various diets.

So many persons, other than those on special diets, became interested in the clinic that a class in normal nutrition, budgeting, wise buying and careful planning was organized. This is held at night under the direction of the hospital dietitian, who has been authorized as a volunteer Red Cross instructor in nutrition. As with the other Red Cross foods classes a certificate is given to each member of the class at the completion of a twenty-seven hour course.

It is hoped that from this humble beginning the Burrell Memorial Hospital will be a place to which the colored people of southwest Virginia will turn for help in solving their problems of what to eat, why to eat it and how to prepare it correctly for normal nutrition, as well as the kinds and amounts of foods to use for special diets. It is also hoped that it will help make the colored people of the community have more confidence in the services of doctors, dietitians and hospitals.

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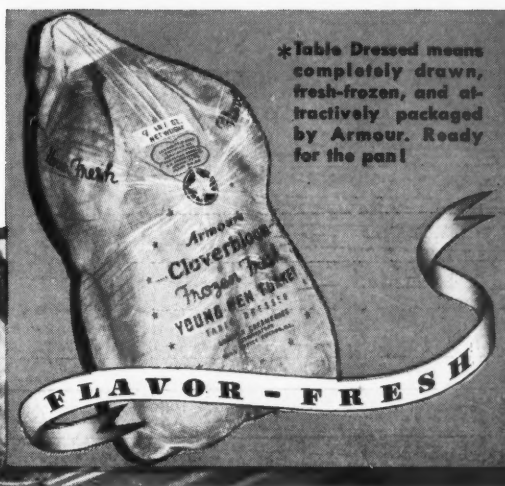
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3. Every Cloverbloom *Table Dressed* bird *must* go into refrigeration within *minutes* after table dressing. This is one of the health-protective requirements in Armour's process of *Table Dressing*. And this speedy handling plus Armour's freezing process insures that every *Table Dressed* bird is *Flavor-Fresh*.

A record of your portion costs will show that Cloverbloom *Table Dressed* birds are not expensive. We believe that one trial box will make you an enthusiastic customer.

Cloverbloom *Table Dressed* Poultry Brings You These Advantages, too:

UNIFORM—Exact grading of *Table Dressed* Poultry means each type and weight is exactly the same, always.

FLAVOR-FRESH—Fresh-Frozen immediately after *table dressing*, this superior poultry has the delicious *fresh* flavor you want.

CONVENIENT—It's ready for the pan...already drawn and perfectly cleaned to make its use as easy as possible.

ECONOMICAL—You save the time taken for drawing. *You always know your portion costs*... The larger amount of meat per bird gives extra servings.

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March Menus for the Small Hospital

Mary Ann McKee

Dietitian, St. Joseph's Mercy Hospital, Clinton, Iowa

BREAKFAST			LUNCHEON OR SUPPER				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Applesauce	Milk Toast	Tomato Bouillon	Cheese Fondue		Perfection Salad	Pears
2.	Orange Juice	Pork Sausage, Coffee Cake	Vegetable Soup	Creamed Asparagus on Toast	Baked Potatoes	Peach and Nut Salad	Chocolate Cake, White Icing
3.	Sliced Bananas	Omelet	Cream of Spinach Purée	Spanish Rice		Carrot-Raisin Salad	Apricots
4.	Prunes	French Toast, Bacon Strips	Beef Broth With Noodles	Mashed Sweet Potatoes With Marshmallows		Cream Coleslaw	Peanut Butter Cookies
5.	Tomato Juice	Scrambled Eggs	Oyster Stew	Apple Fritters		Cottage Cheese, Pineapple and Green Pepper Salad	Jelly Roll
6.	Canned Grapefruit	Bacon	Oxtail Soup	Sautéed Mushrooms on Toast		Fruit Gelatin	Mint Ice Cream
7.	Figs in Syrup	Hot Cakes With Syrup	Cream of Tomato Soup	Salmon Salad	Potato Chips	Shredded Lettuce- Green Pepper Salad	Red Raspberries
8.	Fresh Rhubarb	Baked Eggs With Bacon Strips	Vegetable Soup	Welsh Rabbit on Toast		Waldorf Salad	Spice Cake
9.	Tangerine Sections	Grilled Ham, Muffins	Chicken Soup	Assorted Cold Meats, Deviled Eggs	Baked Potatoes	Cabbage, Pineapple, Raisin Salad	Oatmeal Cookies
10.	Pineapple Juice	Soft Cooked Eggs	Cream of Mushroom Soup	Escalloped Tomatoes		Stuffed Celery	Sliced Peaches
11.	Stewed Apricots	Rice Pancakes With Syrup	Beef Broth With Rice	Garden Casserole		Orange and Grapefruit Salad	Butterscotch Pudding
12.	Baked Apples	Milk Toast	Vegetable Soup	Egg Croquettes		Frozen Peas	White Cake, Chocolate Icing
13.	Italian Plums	Bacon	Tomato Bouillon	Frankfurters in Blankets		Buttered Beets	Pineapple Tapioca
14.	Sliced Oranges	Shirred Eggs	Cream of Pea Soup	Creamed Salmon		Perfection Salad	Chocolate Ice Cream
15.	Sliced Bananas	French Toast With Syrup	Beef Broth With Barley	Escalloped Veal and Tomatoes		Cream Cheese and Peach Salad	Sugar Cookies
16.	Grapefruit Juice	Cinnamon Rolls, Sausage	Chicken Soup	Baked Sweet Potatoes, Grilled Apples and Bacon		Coleslaw	Cherry Cobbler
17.	Stewed Peaches	Coddled Eggs	Oxtail Soup	Creamed Chipped Beef on Toast	Mashed Potatoes	Baked Carrots	Fruit Cup
18.	Rhubarb	Bacon	Cream of Asparagus Soup	Creole Omelet		Peas, Cheese and Celery Salad	Rice-Raisin Pudding
19.	Applesauce	Cheese Omelet	Vegetable Soup	Chicken Salad	Creamed Potatoes	Ginger Ale-Fruit Gelatin Salad	Blueberry Muffins, Pears
20.	Fresh Grapefruit	Grilled Ham	Oyster Stew	Cold Meats, Deviled Eggs		Mixed Vegetable Salad	Gingerbread, Whipped Cream
21.	Canned Figs	Poached Eggs	Cream of Potato Soup	Fried Corn Meal Mush		Orange and Grapefruit Salad	Baked Custard
22.	Tomato Juice	Pancakes With Syrup	Mulligatawny Soup	Eggs and Asparagus au Gratin		Carrot and Cabbage Salad	Plums
23.	Tangerine Sections	Coffee Cake, Omelet	Chicken Soup	Fruit Plate	Potato Chips	Cottage Cheese and Green Pepper Salad	Chocolate Cake
24.	Stewed Prunes	Bacon	Cream of Split Pea Soup	Hungarian Goulash		Head Lettuce Salad	Iced Graham Crackers
25.	Pineapple Juice	Scrambled Eggs	Vegetable Soup	Sautéed Mushrooms on Toast		Molded Fruit Salad	Caramel Ice Cream
26.	Italian Plums	Pancakes With Syrup	Cream of Tomato Soup	Baked Macaroni and Cheese		Waldorf Salad	Apricots
27.	Sliced Bananas	Grilled Ham	Oxtail Soup	Link Sausages	Candied Sweet Potatoes	Celery and Olives	Lemon Pudding
28.	Stewed Apricots	Baked Eggs	Cream of Asparagus Soup	Escalloped Tuna and Peas		Fresh Fruit Salad	Pineapple Tapioca
29.	Orange Juice	French Toast With Syrup	Beef Broth With Noodles	Chicken Salad	Creamed Parsley Potatoes	Buttered Peas	Pears
30.	Grapefruit Sections	Cinnamon Rolls, Sausage	Chicken Soup	Creamed Asparagus on Toast	Baked Potatoes	Combination Salad	Raspberries
31.	Baked Apples	Coddled Eggs	Cream of Green Bean Soup	Baked Noodles and Mushrooms		Coleslaw	Fruit Gelatin With Whipped Cream

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

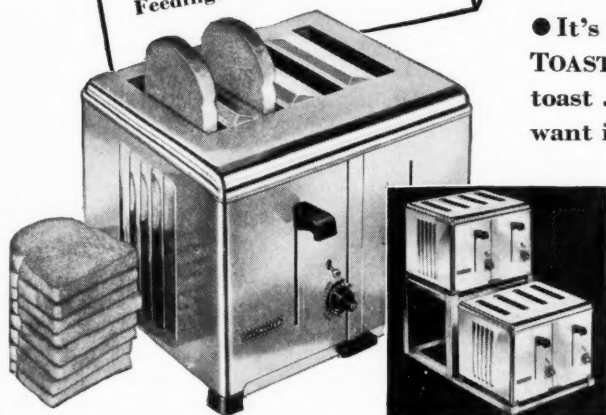
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DINNER TRAY

- Creamed tunafish on crisp, hot Toastmaster toast, garnished with pimienta strips; baked potato and green peas; orange and grapefruit salad with French dressing; blue plums; coffee.
- TOAST is an attractive, easily digestible form of carbohydrate, ideal for Bland Diets, Surgery Diets, Smooth Diets, Low Residue Diets and as a supplementary food in Infant Feeding.

Two slices...or two hundred...
Toastmaster Toaster makes toast fast
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● It's never easy to please ailing appetites but much easier when TOASTMASTER TOASTER helps you serve piping-hot, crunchy toast . . . as fast as you need it . . . as delicious as your patients want it! You'll like the understanding way it works for you and thinks for itself—times each slice, crisps it a golden luscious brown, then pops it up and clicks off the current to prevent needless waste. Your patients will like the rich, appetite-teasing flavor of Toastmaster Toast that tastes like home . . . and makes the hospital more pleasant to remember!

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 Made in 2, 3, 4, 6, Duo-8, 12 and Duo-16 slice models with capacities from 110 to 870 slices per hour. The Duo-8 slice model (illustrated above at right) is ideal for the average diet kitchen. Toasts 435 slices per hour in less than a foot of space.



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This illustrated booklet contains many interesting tray set-ups, recipes for toast dishes, sandwiches, etc. **Send for it today.**

The Housekeeper as Fire Warden

LEONARD F. MAAR

Safety Research Institute, New York City

FEW persons associated with hospital management are in a better position than the housekeeper to obviate the danger of fire in the institution. Many fires can start in her domain but if she is alert to the hazards involved she can prevent many of them and can also help to safeguard the hospital when fire does occur.

A cardinal rule of fire safety is good housekeeping, a condition for which the housekeeper is responsible. This implies training maids and porters to understand the few essential facts. Hospital executives are aware of the danger of fire but the nonprofessional worker is less likely to have this consideration in mind. The staff meeting affords the housekeeper an excellent opportunity to impress her workers with the value of fire prevention and protection.

The locations where maids and porters are most likely to encounter fire hazards are the wards, private rooms, corridors, the sewing room and the rooms used for the storage of linen. If the laundry is under the housekeeper's supervision also, there are hazards here that should be recognized and eliminated.

The storage and handling of cleaning fluids and polishes often present dangers. Housekeepers should know the nature of the materials used. Some cleaning fluids have as a base a flammable solvent, such as benzene or alcohol. It is a mistake to use such dangerously flammable liquids inside any building. There are non-flammable solvents that will accomplish equally good results.

Some furniture polishes have bases of linseed or other vegetable oils. Cleaning cloths saturated with these oils are subject to spontaneous ignition. Housekeepers should explain to their staffs the process of spontaneous ignition and how it can be controlled.

Oils, particularly the vegetable oils, oxidize and in the process heat is generated. A cloth saturated with such a polish, inadvertently allowed to remain in a closet and perhaps covered with soiled linen or some other combustible material that will keep out the air, is a dangerous fire hazard. If the heat generated by the oxidization cannot escape, the fabric will grow hotter until it smolders and burns. Polishing cloths should be disposed of at the end of each day.

Accumulations of combustible rubbish are always dangerous because any chance spark or flame may ignite them. Sweepings, the refuse from

A safety engineer points out some of the possible fire hazards that are to be found in the housekeeping department and the ways in which the housekeeper can eliminate them

waste baskets and such material should be taken from all floors each day and burned in the incinerator.

Maids and porters have many opportunities for inspecting the portable electric cords used to connect lamps and appliances. When they find cords that are worn or frayed, they should notify the housekeeper of the condition so she can have it corrected. Defective electric appliances cause many fires.

Closets in which mops and brushes are kept should be scrupulously clean. Linen storage rooms should be inspected often to make certain that aisles are clear and that all is in good order. The same supervision

should be exercised in the sewing room, with special attention to electric connections for sewing machines.

In such rooms, care should be taken that electric lamps do not come in contact with combustible material for the heat from lamps often is sufficient to start a fire.

In the laundry, the sorting of soiled garments requires special attention. If the oily overalls or work jackets worn by the engineer's staff are cleaned, there is danger of spontaneous ignition when they are piled up with other clothing. These garments should be sorted out and given special handling.

Clothing of patients, interns or nurses should be inspected before it is tossed down the laundry chute. Matches left inadvertently in a pocket may be ignited by friction as they slide down the chute.

The use of electric hand irons offers many opportunities for fire unless they are properly safeguarded with thermostatic controls. In the laundry it should be the last duty each night of the person in charge to make certain that all of the irons are turned off.

One of the most difficult hazards to control is the careless use of matches and smoking. In wards or private rooms where smoking is permitted, the housekeeper must provide plenty of ash receivers. Maids and porters should be prohibited from smoking, except in specified areas, and they should be constantly alert for the carelessly discarded cigaret or cigar.

With reasonable diligence, the housekeeping staff can add immeasurably to the fire safety of its institution. Perhaps 50 per cent of all fires can be avoided by the steps outlined. But when the human element fails and fire does occur maids and porters should know exactly what to do to minimize the danger.

Since hospitals are occupied every hour of the day, there is an excellent chance of a fire's being discovered



M. BURNEICE LARSON, DIRECTOR

YOUR CHANCE FOR ADVANCEMENT

Most of you are aware of the great significance the personnel needs of National Defense may have for you . . . not only for those of you who have answered calls from the Army, the Navy, the Red Cross—but for you who may secure the desirable positions which have been left open as a result of these calls.

Under ordinary conditions the people leaving these positions would have parted from them only by death or promotion—but these are not ordinary times! We have for several months been placing men and women trained in various phases of hospital service in positions for which they might have waited many years, were it not for the unprecedented number of vacancies created by the Defense Program.

Where are these positions? You may know of a few in your own community—but perhaps they are not interesting to you. If you will file your qualifications with us now, you can begin receiving descriptions of opportunities in all parts of the country, and continue receiving them until you suddenly come upon the one opportunity you wouldn't think of missing!

If you have not already done so, write us today. A registration form will be mailed you at once so that you may acquaint us with your qualifications and requirements. You may rely upon us to keep your correspondence with us in complete confidence.

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PALMOLIVE BUILDING, CHICAGO

almost as quickly as it starts. Prompt action can then prevent the spread of flames and can spare patients the confusion and excitement that attends a fire emergency.

All hospital workers should know how to use the fire extinguishers. They should know where the equipment is located on every floor. This too, should be the subject of staff meeting discussions. If there is a program of fire training for nurses,

the housekeeping staff should be included in fire drills and in demonstrations of first-aid fire appliances. They should be shown where fire alarm boxes are located and instructed in their use.

Although all this may appear complex to the housekeeper, it is really quite simple and can be made a part of her supervisory routine without adding appreciably to her responsibilities.

War Declared on Pests!

MABEL AGNES BAILIE

Resident Director, Rockford College

SEVERAL species of ants invade buildings and get into food supplies and otherwise annoy the occupants. They form colonies in which remain the queen ants that lay the eggs and the young ants that have to be fed by the worker ants. The workers are the ants that are found attacking foods and crawling about. They collect food and carry it back to the nest where they feed it to the queen and the young.

Killing some of these workers merely weakens the colony but does not affect the queens or the development of the young unless so many workers are killed that the colony's food supply is seriously reduced. In fighting ants, therefore, it is essential to locate and destroy the nests, including the queens and the young, for when this is done the other forms usually perish.

If the nest can be found by following back along the line or trail of worker ants as they come to and go from food it is not difficult to kill the colony, particularly if it happens to be located outdoors or in the soil beneath a cracked cement basement floor. Pour 1 or 2 tablespoonfuls of carbon disulphide down the crack and repeat this after twenty-four hours if necessary. Carbon disulphide is a liquid which evaporates upon exposure to air, forming a gas that is heavier than air, so that it sinks into soil and cracks. This gas is explosive and inflammable in the presence of fire in any form, so keep matches, lighted cigars or cigarettes away while using it. Sometimes pouring boiling water into such

cracks will kill the colony if it is not deep-seated.

If the nest is in the soil of the lawn or garden, as indicated by the characteristic ant hills, make holes about 1 foot apart over the infested area with a broom handle or similar object to a depth of from 2 to 4 inches and pour into each hole from 2 to 3 tablespoonfuls of carbon disulphide. Place the liquid below the roots of the grass; otherwise the grass may be killed.

When nests are in the woodwork, find the small openings made by the ants, or, if the nest is close to the surface, make an opening into the ant galleries. Inject through this opening, by means of a pipette or small syringe, a teaspoonful or a tablespoonful of carbon disulphide or orthodichlorobenzene and then close the opening with a plug of plastic wood, putty or similar material. As the ant burrows or galleries may be widely separated it is desirable to make injections through all the openings to the exterior that can be located.

If it is suspected that the ant nest is near a certain point in the wall or floor it may pay to inject a small amount of carbon disulphide or orthodichlorobenzene at that point but this kind of treatment for nests in a building is likely to fail unless the exact location of the nest is determined. Ants often crawl considerable distances in wall and floor spaces from their nests to the point where they emerge into the room and the colony is then too well protected to be killed by means of fumigation.

When colonies cannot be located without tearing out partitions or going to other unwarranted expense, the use of poisoned syrups or baits, powders, sprays or chemical barriers is advocated. No one bait or syrup can be depended upon to destroy all kinds of ants under varying conditions. Some ants will eat one poison and refuse another; some eat only sweets, while others eat only meats and grease.

Sodium fluoride dusted about window sills, drain boards, foundations and other places where ants crawl will sometimes drive them away, but not always. If effective, it makes an easily applied and cheap control. Sodium fluoride is a poison and should be kept away from children.

Ants can be kept off tables, refrigerators or other movable furniture of no particular value by placing the legs of the furniture in shallow dishes or small jars into which a small quantity of kerosene has been poured. Keep the surface of the kerosene free from dense accumulations of dead ants; otherwise live ants may use the bodies of those killed as a bridge to reach the furniture.

Tapes fastened about the legs of furniture will keep ants off and are cleaner than kerosene containers. Prepare these tapes by boiling strips of bias cloth in a saturated solution of bichloride of mercury (corrosive sublimate). After boiling the strips hang them up to dry; wrap them about the legs of furniture and tie them firmly. Corrosive sublimate is a deadly poison.

The ordinary kerosene pyrethrum spray heretofore mentioned is excellent for killing ants if they are actually hit by the spray. Sometimes spraying will keep ants away but it is seldom that sprays can be depended upon to kill a colony.

When other methods fail, it may be necessary to resort to poisoned baits. First, remove all foods from the places to which ants have been coming and substitute a saucer or other dish containing a sponge kept moist by poisoned syrup. The worker ants will feed upon the syrup, carry it back to the nest and feed it to the queens and the young and so poison the colony. Sometimes the poison container can be placed along the line of march followed by the ants rather than about the sink, pantry or kitchen cupboards.



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Hospital Pharmacy

Why Hire a Pharmacist?

R. G. BODWELL

Administrator, Huron Road Hospital, Cleveland

THE dispensing of drugs is one of the most important services that a hospital must provide. Technician in the care of the sick and injured has made rapid strides in the past few years and no longer is a drug room located in some obscure corner of the building.

Drug therapy holds an important place in the practice of medicine and any modern hospital of today must be prepared to provide this service for the physician. The medical profession, as well as hospital administrators, realizes the importance of the efficient pharmacy. The American Medical Association and the American College of Surgeons recommend the establishment of such a department and expect approved hospitals to comply with the requirements that have been promulgated. The American Hospital Association and most state associations now include pharmacy sections.

Violation of State Laws

Many hospitals, particularly the smaller ones, rely largely upon neighboring drug stores for prescriptions and special drugs, their own limited stocks being dispensed by nurses, technicians or other hospital personnel. This procedure is inconvenient and costly and often results in delays that are annoying to patient and physician. Nurses cannot perform their regular duties efficiently when they are constantly being interrupted to tend the drug room. The question might well be raised as to whether this procedure, in many cases, is not in violation of state pharmacy laws.

The problem of the small hospital that does not have a sufficient volume of work to warrant the employment of a pharmacist can easily be solved by assigning him many other duties. His training and instincts make him versatile. He is particularly adept in purchasing not only drugs but surgical instruments and supplies and hospital supplies in general. Being painstaking and sys-

tematic, he is well qualified to receive, sort and store all hospital supplies. He can keep inventories of hospital property and see that there is a proper supply on hand at all times. He should be able to fill all requisitions and take charge of the distribution of supplies.

Centralized Purchasing

The small hospital, and even larger ones, may well give thought to the establishment of a department in which the pharmacy, purchasing, receiving, storing and issuance of all supplies are centralized under the supervision of the pharmacist. In this department, at a nominal expenditure for equipment, all hospital forms and stationery can be duplicated or printed. Paper can be purchased in stock sizes at wholesale prices and cut to required size, and printing and stationery costs can be reduced.

Such a setup can be handled by the pharmacist or by assistants under his supervision to the advantage of the hospital.

The pharmacist can also make himself of value to the hospital in many other ways. He can be put in charge of sterilization, supervise disinfection, manufacture insecticides and cleaning compounds for the housekeeping department, prepare developer for the x-ray department and repair surgical instruments and other items that might otherwise be discarded.

I am not suggesting that the pharmacist should be a handy man around the hospital but am merely pointing out to those hospitals in which duties must be combined the possibilities of making a full-time pharmacist a real asset in terms of both service and economy.

In colleges of pharmacy young men and women receive basic training in chemistry, physiology, bacteriology and pharmacology. Each

year more graduates of pharmacy schools are seeking hospital internships; hospitals should offer these internships for their own benefit and as an aid in the development of a profession that is highly important to medicine and to hospital administration.

In his own field the pharmacist will add prestige to and raise the standards of any hospital regardless of its size. He will cooperate with the medical staff and will add important safeguards for the patient. In many ways he will be helpful to the doctor who is too busy with his own practice to keep abreast of the new drugs and therapeutics. He may take part in the teaching program in the schools of nursing.

Exchange of Information

The pharmacist can introduce into the hospital many new procedures that he learns through his association with other pharmacists and from information gained through an interchange of experience.

The pharmacist will be able to purchase many proprietaries under their official names instead of under trade names. Preparation of the more commonly used compounds, extracts and mixtures can be another source of economy. This is particularly true of preparations containing ethyl alcohol because of the savings in the payment of tax. Tablets can be economically made with the purchase of a tablet making machine at small cost.

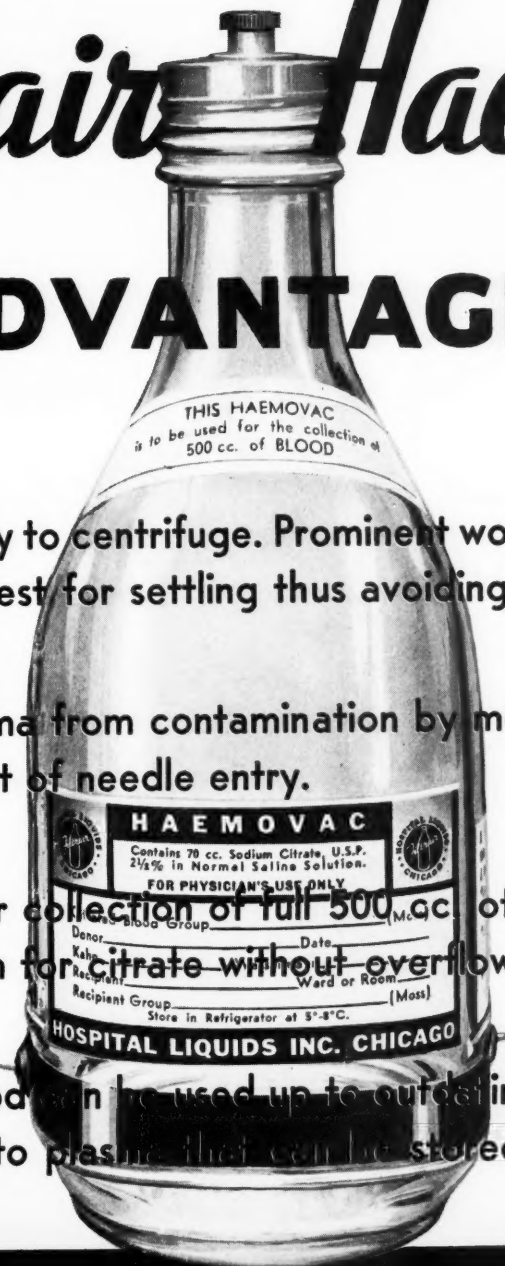
The pharmacist should set up a formulary standardizing drugs and prescriptions. Standardization will cut down the variety of drugs stocked to a considerable extent and in other ways will simplify the pharmacy procedures.

Every hospital should give the same consideration to building up an efficient pharmacy service as it gives to its other professional departments.

for Plasma

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ADVANTAGES



1. No necessity to centrifuge. Prominent workers find this type container best for settling thus avoiding breakage loss.
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For descriptive literature write to

HOSPITAL LIQUIDS

CHICAGO *Incorporated* NEW YORK

Table of Local Treatments for Burned Areas, Showing Agents, Indications and Technics

<i>Agent</i>	<i>Indications</i>	<i>Advantages</i>	<i>Disadvantages</i>	<i>Technic</i>	<i>Reference</i>
Greases and ointments:					
Oils, vaseline, carbon oil, boric acid Cod liver oil ointment Scarlet red ointment	Burns of small area First degree burns Burns around body orifices, fingers, hands, toes, face or joints	Anesthetic may be added Dressings do not adhere Stimulates granulation after removal of eschar	Fluid escapes Not enough antiseptis Changing dressing is painful Changing dressing allows infection	Debride and apply agent Place dressings firmly Change dressings frequently	
Intermittent or continuous baths and wet packs: Water, saline, boric, aqueous green soap Burow's solution, eusol, Dakin's solution, hexylresorcinol	Untreated burn with weeping crust Fire burns with dense coagulum Areas about genitalia Preparation for grafting	Areas kept clean No trap for pyogenic infection Sterilizing of dead tissues more rapid Contractions prevented by supported movements	Fluid loss not checked Apparatus not at hand Needs constant attendance	Treat shock From 5 to 10 minutes bath and debridement Packs applied between soaks Daily soaks (packs soaked off); increase time from 30 minutes to hours Exercise in bath	Lavender, Cincinnati
Dry heat	Adjuvant in slow eschar formation	Serum coagulates Prevents sepsis	Patient already has fever Increased loss of fluids	Sterile sheets Heat cradle or cage	Wilson, Edinburgh
Picric acid 0.5 percent	Ideal on second degree burns	Rapid analgesia	Toxicity—absorbed through viable skin	Apply only to burned areas	
Paraffin	Emergency in industrial plants	Speed of application	Infection in changing Not antiseptic Does not prevent fluid loss	Spray; wrap with cotton; spray	
Eschar forming agents: Tannic acid, from 2.5 to 7 percent Tannic acid jelly	 Face	Retains fluids Prevents toxic absorption	Contracts pores of skin Stiff and board-like. From 24 to 48 hours to form eschar Infection beneath	Treat shock; give morphine or codeine Nitrous oxide—ether anesthesia (if necessary) Scrub from 5 to 7 minutes with green soap and peroxide Alcohol and hexylresorcinol lavage Debridement Sterile bed with cradle	Davidson, Detroit Low, Boston
Compound solution tannic acid (20 percent tannic acid and 0.1 percent salicylic acid in Ringer's solution)		Solution kept in stock Denser coagulum Bacteriostatic action		Spray every 15 or 20 minutes	Fantus, Chicago
5 percent tannic acid plus 10 percent silver nitrate	(Better on movable areas) Third degree burns on 15 percent of body or more	Strong antiseptic Eschar softer, thinner, rubbery Rapid formation of eschar Can cover with bedclothes Positions can be varied Continued spraying unnecessary	Slight tendency to keloid Argyria—not seen Destruction small skin islands by silver nitrate	As immediately above plus: Apply silver nitrate over first coat tannic acid Eschar in minutes, not hours	Bettman, Portland, Ore.
20 percent tannic acid plus 1 percent gentian violet Tannic acid and hexylchlororesorcinol	Third degree burns on 15 percent of body or more	More rapid eschar Bacteriostatic			Wilson, Edinburgh Hartman and Schelling, Detroit
Gentian violet 1 percent Cresyl violet 1.5 percent Acridine 0.75 percent Brilliant green 1.0 percent	Third degree burns on 15 percent of body or more	Specific for gram positive organisms Scrub or anesthesia not absolutely essential Eschar more pliable Does not hide infection Follicle skin islands intact Acridine violet specific for gram positive and negative organisms	Stains bedclothes More expensive Slow in application and eschar formation Stains tissues	Clean off oil or ointment Not extensive debridement (loose tissue and foreign bodies) Place under heat cradle Spray every hour Eschar in 8 to 24 hours	Aldrich and Firor, Boston Aldrich, Boston
Ferric chloride: Tincture ferric chlor. 15.0, sodium hydroxide 0.3, distilled water q. s. ad 30.0	Third degree burns on 15 percent of body or more	Solutions stable Coagulum flexible Small infections easily found	Stains bedclothes		Coan, Wyandotte, Mich.

*Harold Chase, M.D.
Wayne University, Detroit*



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A Sure Hand . . .

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MALLINCKRODT ETHER for Anesthesia

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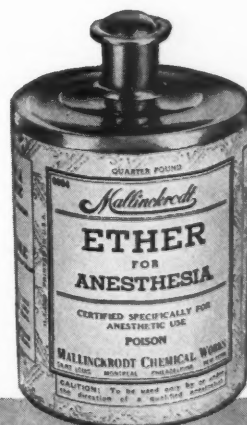
Procaine Hydrochloride U.S.P. XI

MALLINCKRODT Cyclopropane* U.S.P. XI

Paraldehyde U.S.P. XI

Chloroform U.S.P. XI for Anesthesia

* Cyclopropane (Mallinckrodt) may also be obtained through the various offices of the Puritan Compressed Gas Corporation of Kansas City.



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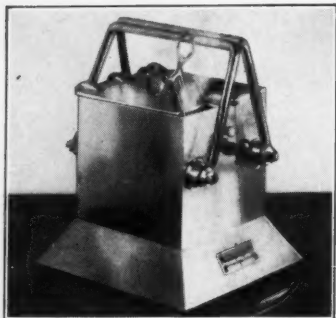
Philadelphia

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TOMAC Sterilizer**



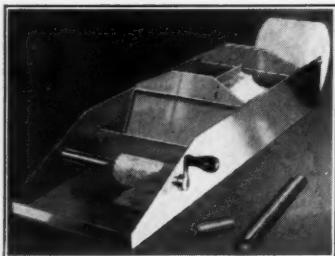
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**Make Perfect
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**... One A Minute
And At A Fraction
Of The Usual Cost!**

Better and *less expensive* than any you can buy. Every bandage has just the right amount of plaster on its crinoline base. Makes bandages 2" to 8". 4" size costs less than 4c. Ask us for a demonstration.



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News in Review

President Urges Attention to National Health; Wagner Outlines Program

In his message to Congress on January 6, President Roosevelt included improvement of health conditions as one of the important domestic safeguards to democracy. While full aid should be given to the countries fighting against totalitarian regimes, "certainly this is no time to stop thinking about the social and economic problems that are the root cause of the social revolution which is today a supreme factor in the world," the president stated.

Speaking more specifically, he asserted: "Many subjects connected with our social economy call for immediate improvement. As examples, we should bring more citizens under the coverage of old-age pensions and unemployment insurance; we should widen the opportunities for adequate medical care; we should plan a better system by which persons deserving or needing gainful employment may obtain it."

On the day following the President's speech, Senator Robert F. Wagner of New York announced that a comprehensive proposal for an expanded national health program in line with the President's recommendation was being prepared for introduction in Congress. Last year Senator Wagner's hospital construction act was approved by the Senate

committee on education and labor but never reached a vote in the Senate. Senator Wagner said that some changes would be made in drafting the new bill.

"We are already getting a lot of the hospitals that we were aiming at in the original bill," Senator Wagner stated in an interview. "They are being built now by the government to take care of the boys who are in training camps, so at least a part of the program has become effective."

Newspaper accounts say that the tentatively outlined bill would provide a federal contribution of \$35,000,000 the first year toward the operation of approved state plans for general medical care; \$10,000,000 for temporary disability compensation; \$8,000,000 for hospital construction; \$13,000,000 for medical services for children; \$15,000,000 for general public health work; \$8,000,000 for maternal and child health service, and smaller amounts for administration and for investigations.

These statements indicate that Senator Wagner expects to reintroduce his national health act in modified form rather than his national hospital act, which was the bill that was originally approved by the Senate committee on education and labor.

Albany Hospital Starts Training of N.Y.A. Workers

Two important moves toward better national defense were taken recently in Albany, N. Y. A series of health lectures for the public on the methods of maintaining health during defense mobilization has been organized by Albany Medical College and Hospital in cooperation with the local county medical society and the hospital council of Albany.

The first address was by Governor Herbert H. Lehman. Local civic clubs joined in sponsoring the lecture.

The second activity is a program for the training of nurse aids, kitchen maids, cleaning maids, porters, mechanics and laboratory technicians. This program is to be carried on at Albany Hospital in cooperation with the National Youth Administration and is the biggest private project in upper New York State. More than \$5000 has been set aside to pay the wages of these N.Y.A. workers during the training period.

Program of New England Assembly


The annual meeting of the New England Hospital Assembly will convene at the Hotel Statler, Boston, March 12 to 14. The program for the three day session will include discussions of the problems of small hospitals; an adequate program of public relations; preparedness; continuing education for hospital personnel, and rehabilitation of the patient. A special session for trustees will be held Thursday evening, March 13. The meeting will close with a banquet on Friday night.

\$1,250,000 for Ohio Hospital

A bequest of \$1,250,000 has been made to Butler County, Ohio, for the building and maintenance of a hospital for communicable and infectious diseases. The money will not be available for use until June 1942 under the terms of the will of the donor, Eugene H. Hughes, who directed that it be invested for three years after date of his death. Mr. Hughes died in June 1939.

Hollister Birth Certificate Service

Saint Joseph's Hospital
Mankato, Minnesota



This Certifies that _____
was born to _____ m. _____
the _____ day of _____ A.D. 19____


In Witness Whereof the said Hospital has
caused this Certificate to be signed by its duly
authorized officer and its Corporate Seal to
be hereunto affixed.

Superintendent

Attending Physician

Form F. Actual size, 10 $\frac{1}{8}$ x 8 $\frac{3}{8}$

Valley Baptist Hospital
Harlingen, Texas



This Certifies that _____
was born to _____ m. _____
the _____ day of _____ A.D. 19____

In Witness Whereof the said Hospital has
caused this Certificate to be signed by its duly
authorized officer and its Corporate Seal to
be hereunto affixed.

Superintendent

Attending Physician

Form K. Actual size 10 $\frac{1}{8}$ x 8 $\frac{3}{8}$

BIRTH CERTIFICATE

Clearfield Hospital
Clearfield, Pennsylvania

This Certifies
That _____
was born to _____ m. _____
the _____ day of _____ A.D. 19____

In Witness Whereof the said Hospital has
caused this Certificate to be signed by its duly
authorized officer and its Official Seal to
be hereunto affixed.

Superintendent

Attending Physician

Form A—Hollister Birth Certificate Design ©1938 Franklin C. Hollister Chicago

Remember the Creator in the days of the youth

Form A. Actual size 10 $\frac{1}{8}$ x 8 $\frac{3}{8}$

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Duplex Birth Certificate Frames
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PUBLICIZE THE QUALITY OF YOUR MATERNITY SERVICE

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Form F—This de luxe form is especially recommended because of its distinctly individual character, made so by the showing of a fine lithoplate picture of hospital. This picture identifies your certificate at a glance, making it the best sort of publicity. Lithographed to order.

Form K—All the elements of quality which distinguish Form F are carried through on Form K. The distinctive feature of this form is a charming illustration of Mother and Child, in an artistic setting, which is substituted for picture of hospital. Lithographed to order.

Form A—Long our most popular certificate because of its highly attractive border, has been redesigned by hand lettering in Spencerian script and Old English text. Lithographed in large quantities for economy in production, kept in stock and imprinted as ordered. Sold in lots of 25 and up.

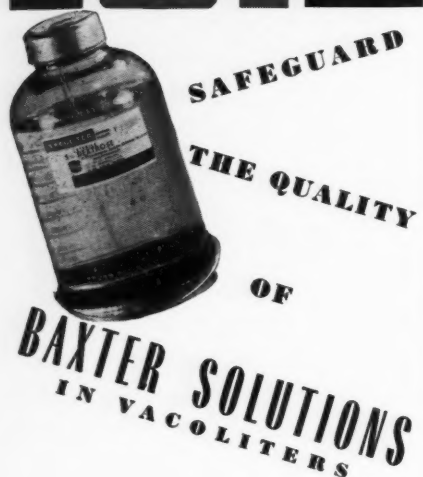
Elements of "Hollister Quality"

Designed by skilled photograph retouchers and letter artists. Produced by offset lithography on 100 lb. Hurlbut Diploma Parchment—100% all new white rag content—more lasting than the papyrus scripts of ancient Egypt. Forms are arranged for babies' footprints, mothers' thumbprints, and family history on the backs of certificates. Gold wafers are attached for impression of official seal. Each certificate is enclosed in envelope to match. Tied in 50's with rayon silk tape; put up 100 in attractive box; shipped in strong cartons for protection in transit. All forms of Hollister birth certificates are copyrighted.

Write Department E for sample of certificate you prefer. Price list and descriptive circulars will also be sent.

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538 West Roscoe Street, Chicago, Illinois, U. S. A.

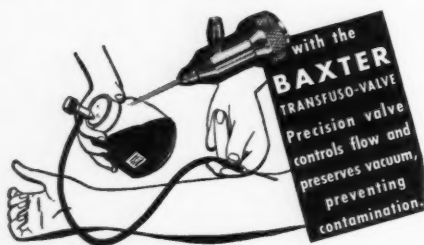
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CHICAGO NEW YORK

Committee to Aid British Hospitals Is Organized by New York Association

Organization of 102 New York hospitals for the collection of surgical equipment, medical supplies, funds and clothing to aid British hospitals was announced last month by the Greater New York Hospital Association.

James U. Norris, superintendent of Woman's Hospital, is chairman of the Committee to Aid British Hospitals, which will carry out the aims of a resolution unanimously adopted by the association pledging full cooperation to the British War Relief Society in raising money and supplies through the member institutions of the New York hospital group.

Mr. Norris reported that 50 per cent of all British hospitals have been damaged in air raids and are in urgent need of assistance. Each hospital in the association has been asked to set up its own committee.

Activities suggested by the committee include the contribution of medical samples received by hospital staff members; collection of all discarded but still serviceable surgical equipment; fund raising through benefit parties, and knitting by nurses and other women employees.

Administrators' Institute at University of Minnesota

The annual continuation course in hospital administration was held at the University of Minnesota, January 27 to February 1. The program included sessions on principles of hospital accounting, collection methods, telephone service, liability inspection, purchasing of drugs, administration reports, house-keeping service and linen control, plumbing sanitation and efficient heating plant operation. All sessions on Friday, January 31, were devoted to problems of trustees. Demonstrations were held at several hospitals in Minneapolis and St. Paul. Approximately 75 persons registered for the course.

"Siege" Hospital for England

A prefabricated, 126 bed "siege" hospital, to be shipped to England, is under construction in this country. The hospital will be operated jointly by the American Red Cross and the Harvard University public health unit. When the hospital is completed, 75 American doctors, Red Cross nurses and laboratory technicians will make an extensive laboratory and field study of communicable diseases under wartime conditions and report their findings to the U. S. Army, Navy and Public Health Service.

Preparedness to Be Theme of Western Hospitals' Meeting

"Hospital Preparedness in a Democracy" will be the general theme of the Association of Western Hospitals' convention in San Francisco, March 3 to 6. Six general assemblies will be held, all centering around the idea of preparedness. The afternoon program on Monday, March 3, will be sponsored by the Western Conference of the Catholic Hospital Association.

The subjects to be discussed at the general assemblies include: "The Effect of a National Emergency on Hospital Organization"; "Educational Factors in Meeting a National Emergency"; "Purchasing Problems in Relation to Hospital Preparedness"; "Hospitalization for All People," and "Balancing the Hospital Budget."

Among the speakers who are scheduled to appear are Dr. A. C. Bachmeyer, president of the American College of Hospital Administrators; Dr. B. W. Black, president, American Hospital Association; Dr. L. R. Chandler, dean of Stanford University Medical School; Sister John of the Cross, hospital consultant, Mount St. Vincent, Seattle, and Ellard L. Slack, president-elect of the Association of Western Hospitals.

Add New Sections to Tri-State

Three new sections of the Tri-State Hospital Assembly have been scheduled for the meeting of this organization which will be held in Chicago on May 7, 8 and 9. The new sections are for trustees, purchasing agents and office personnel. This brings the total number of participating organizations and sections to 50. The general topics for the morning assemblies are: "Present Trends Affecting Hospital Administration and Service"; "Business Methods in the Hospital," and "Health Service for Hospital Personnel and the Tuberculous Patient in the General Hospital."

New Journal on Medical Care

The first issue of a quarterly periodical, *Medical Care*, was published January 21. The new journal is a non-profit enterprise under the auspices of the Committee on Research in Medical Economics, Inc., with Michael M. Davis, chairman of the committee, as its editor. Williams and Wilkins Company are the publishing agents. Its purposes are "to disseminate information concerning the economic and social aspects of medicine; to promote a scientific approach to the subject, and to stimulate practical action by the professions and the public in their common interest. The views and interests of the professions that furnish medical care and of the people who receive it are equally to be considered."

The Newer Concepts of Meat in Nutrition

Meat

and the Growth Needs of the Child

THE phenomenon of growth is dependent upon a large number of factors for its normal continuation. Second only in importance to the specific effect of the growth hormone elaborated by the anterior pituitary lobe is the influence of the nutritional state upon the growing child.

From a biochemical standpoint growth consists of the ability of the organism to retain certain dietary elements and to utilize them not for energy or storage purposes but for adding to the mass of the organism in an orderly, coordinated fashion. Thus the metabolic output in terms of calories is less than the intake, the difference being utilized to a large extent for growth.

Since a large proportion of the weight gains of infants and children consists of increase in the size and bulk of muscular and other tissues, the protein intake must be adequate not only in quantity but also in quality. Meat, one of the excellent and abundant sources of complete protein, provides all of the essential amino acids found indispensable for growth. Meat also contains appreciable amounts of phosphorus and iron, and of the vitamins B₁ (thiamine), G (riboflavin), and the P-P factor (nicotinic acid). Readily digested, meat properly prepared may be advantageously given to children early in life together with the other foods dictated by the child's age.

The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



American Meat Institute
CHICAGO

Pennsylvania Supreme Court Rules in Favor of Hospitals in Union Fight

A decision of great importance to hospitals was handed down last month by the supreme court of Pennsylvania in the case of Western Pennsylvania Hospital, et. al. v. the Pennsylvania Labor Relations Board and the Hospital Workers Local Union No. 255, et al.

Some 25 hospitals had refused to execute a proposed agreement with the unions or to negotiate any agreement and the unions then appealed to the Pennsylvania Labor Relations Board, charging

unfair labor practices on the part of the hospitals. The hospitals stated that the formation of a union among hospital employees would result in demands that would jeopardize the financial ability of the hospitals to continue operation and, furthermore, that strikes or similar interruptions would jeopardize the safety of patients.

The lower court granted an injunction against the state board and the unions and this was upheld by the supreme

court which stated that a hospital is not an industry nor are its employees engaged in a single trade, craft or occupation.

"It has not been the custom in the past to unionize hospitals," the court stated. "The effect of unionization and attendant efforts to enforce demands would involve results far more sweeping and drastic than mere property rights. . . . It is not merely a question of suspending operations, ceasing work and stopping production, such as might be true in a steel mill or automobile factory. It is a question of protecting the health, safety and, in many cases, the very lives of those persons who need the service a hospital is organized to render. The results are quite different and more extensive than are involved in an ordinary labor dispute. We cannot conceive that the legislature intended to include hospitals within the purview of the act (state labor anti-injunction act). Consequently, even though the words used might conceivably be broad enough to include a hospital, nevertheless, a hospital is not within the spirit of the act and, not being within the spirit, the act does not apply."

The court also held that the Pennsylvania Labor Relations Act did not apply because "hospitals are scientific institutions created for a humane purpose in amelioration of the sufferings of mankind." Pointing out that they require the well-coordinated services of many people, the court held that "this would be impossible, should we hold the labor act applicable with all its attending ramifications, interruptions, and possible cessation of service due to labor disputes and attending financial inability to function." The court also pointed out that the hospitals are, with few exceptions, agencies selected by the state to assist in the care of the indigent sick.

SPAL DOES 3 JOBS soap can never do!



STREAKS and dull surface film vanish from hospital floors . . . dirt floats away. There's a sheen on the floor—lustrous—protective. With one sweep of the mop, your janitor completes 3 jobs that soap can *never* do!

That's the sort of cleaning job Spal does. It's fast . . . thorough . . . safe to use . . . and it gives you economies that count.

That's because Spal's amazing formula offers a new cleaning method—a new expurgating action that dissolves dirt, draws it to the surface, and floats it away.

But Spal does 2 extra jobs that soap can *never* do. It polishes and it protects. A specially developed filler leaves a lustrous film that reveals the *beauty* of the floor and *guards* the surface from harm.

For top-notch economy use Spal now. You'll find its 3-way labor saving action the best investment for your floors.



**Cleans by the New
Expurgating Action!**



**Gives Floors a
Lustrous Polish!**



**Leaves a Film of
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SPAL
LIQUID SCRUB COMPOUND

Carillon Presented to Hospital

Abington Hospital, Abington, Pa., was the recipient of a carillon presented to hospital and community by Mrs. George F. Tyler in memory of her granddaughter. The carillon was dedicated on December 23 with a brief ceremony and a program of Christmas carols played by William S. McCarthy, carillonneur, and sung by the choral group of the school of nursing.

Navy Hospital to Be Constructed

Samuel Hannaford & Sons, architects of Cincinnati, recently announced that they have been commissioned by the Navy Department to prepare drawings and specifications for a naval hospital near Charleston, S. C. The work is to be carried forward at once under the direction of the chief of the bureau of yards and docks.

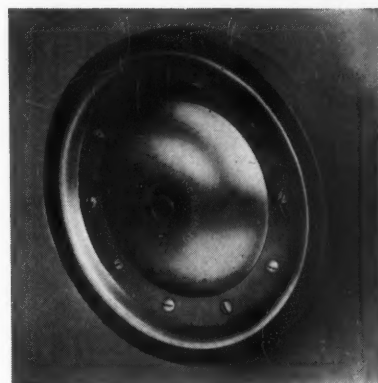
An Important Contribution to SAFETY In Anesthesia!

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JARVIS & JARVIS!

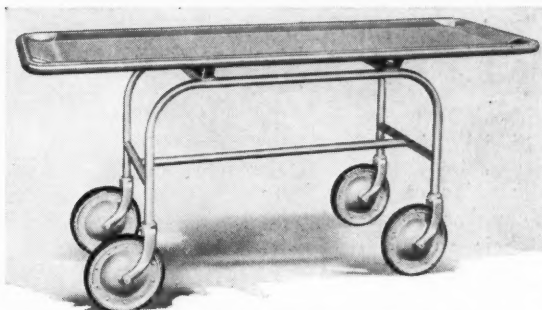
The majority of explosions occurring in closed system anesthesia are caused by static spark. Properly designed pieces of operating room equipment mounted on J & J Conductive Rubber casters and wheels will be in electrical contact with your conductive rubber flooring* and all being at the same potential the possibility of static spark to or from them is eliminated.



J & J

CONDUCTIVE STRETCHERS

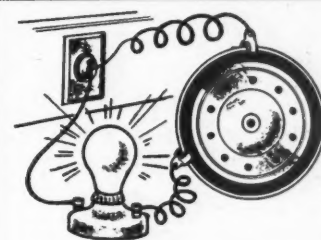
Specially designed and constructed for high electrical conductivity; stretcher-top, smooth, bright cold-rolled stainless steel; all other parts cadmium-plated for maximum conductivity—thus assuring perfect contact between the patient's body and the electrically conductive pad—between this conductive pad and the litter—from the litter to the electrically conductive wheels—



and from the wheels to the conductive rubber flooring. Silence and easy-rolling are assured in this strong, durable stretcher by its 10" ball-bearing wheels, turning on double ball-bearing, self enclosed swivels, and shod with J & J Tires of CONDUCTIVE Rubber. Zerk-fitted throughout for easy lubrication.

Write today for new literature describing J & J CONDUCTIVE Operating Room Equipment. Before purchasing ANY wheeled equipment for ANY department of your Hospital, consult our Catalog 39T, free upon request.

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J&J CONDUCTIVE Rubber Tires for Operating Room Equipment are so highly conductive that they will carry enough current to light a lamp. You can make the test yourself . . . here is positive proof that J&J Equipment will remove one of anesthesia's most serious hazards.

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Enrollment in Hospital Service Plans Tops 1940 Figures by 1,717,000

Enrollment in the 66 approved hospital service plans totaled 6,149,000 on January 1, according to figures compiled by the commission on hospital service. This is a gain of 1,717,000 over the enrollment in the 56 approved plans on January 1, 1940. It represents an increase of nearly 40 per cent and was made in spite of a loss of 100,000 members of the New York plan.

The 10 plans that made the largest growth during the past year were (with the figures on net growth): Michigan, 256,000; Cleveland, 131,000; Pittsburgh, 130,000; Philadelphia, 89,000; Cincinnati, 80,000; Minnesota, 71,000; New Jersey, 61,000; Chicago, 59,000; New Haven, 54,000, and St. Louis, 53,000.

The largest plans at present and the total enrollment of each are: New York City, 1,253,000; Cleveland, 416,000; Minnesota, 381,000; Michigan, 331,000; Pittsburgh, 303,000; Philadelphia, 274,000; Boston, 260,000; New Jersey, 242,000; Chicago, 206,000, and New Haven, 184,000.

Plan Registration of All Nurses in United States

Preparations were made for a roll call of all nurses at a conference held in the United States Public Health Service auditorium in Washington on January 10. State nurses' associations, the American Red Cross, the Nursing Council on National Defense and other interested agencies were represented.

Surgeon General Thomas Parran, who was the principal speaker at the meeting, stated that "the purpose of this registration of nurses is to determine the number of these professional people, their availability for military or civil duty and their special attainments."

The questionnaire to be used in making the survey will go to all registered nurses in the United States and its territories.

Lectures on Military Surgery

A special series of lectures on new methods of military surgery was started at Gotham Hospital, New York City, on January 20. The course is being presented for civilian doctors and for physicians who are expecting to volunteer or to be inducted into the Army Medical Service.

Hospital Given Two Respirators

Two respirators were presented to St. Anthony Hospital, Terre Haute, Ind., as Christmas gifts of the Hulman Foundation, Inc. One of the respirators is for adults and the other, for infants.

Two New York Hospitals Plan New Building Programs

Two New York City hospitals have recently announced plans for new building programs. St. Vincent's Hospital will erect two 10 story buildings and radically alter the existing structures in which the institution is housed. The total cost of the program will be \$3,000,000. The first of the new buildings and the alteration program are expected to be completed by November 1. The other building may not be erected before 1945 but when it is it will replace the existing five story private patient pavilion.

The present capacity of St. Vincent's Hospital is 465 beds and the first of the new buildings will add 120 more. When the whole program is completed the institution will have accommodations for nearly 700 patients.

St. Clare's Hospital on West Fifty-First Street has awarded contracts for the erection of a new building that will be built in the rear of the present hospital and will face on Fifty-Second Street. The new structure will have a capacity of 160 beds, most of which will be devoted to ward patients. The entire first floor will be given over to a large clinic. Robert J. Reiley of New York is the architect.

Pay Tribute to Asa S. Bacon

Nearly 300 hospital leaders from all parts of the Middle West gathered in Chicago on January 15 to pay tribute to the work and worth of Asa S. Bacon, who on January 1 became superintendent emeritus of Presbyterian Hospital, Chicago, after forty years of service. The occasion was Mr. Bacon's seventy-fifth birthday. Dr. N. W. Faxon, director, Massachusetts General Hospital, Boston, made the principal address.

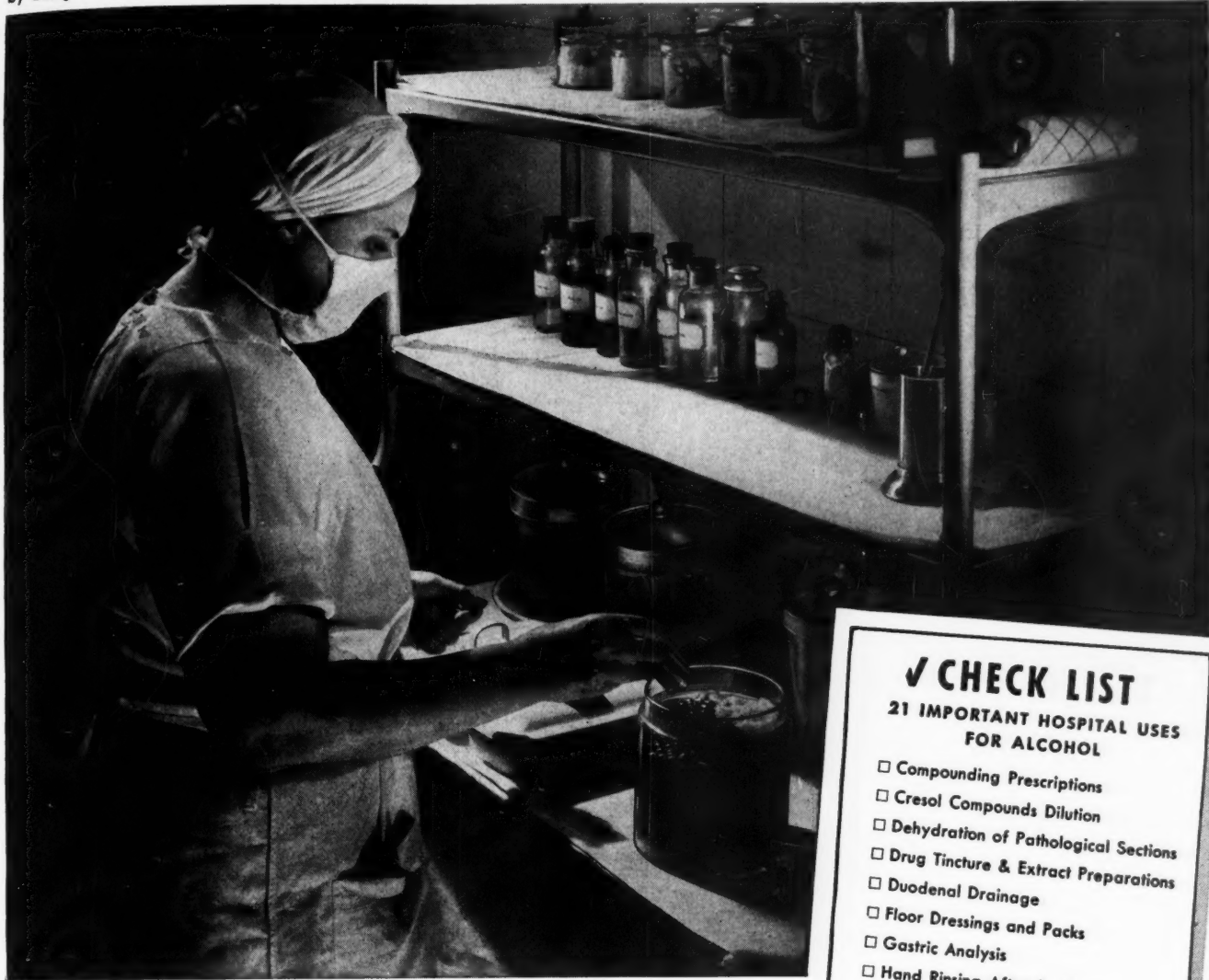
Academy Seeks Endowments

An advisory committee of the New York Academy of Medicine, New York City, has recently been organized to aid the academy in raising funds to meet the demands of its constantly expanding services. The committee will try to obtain \$1,250,000 in endowments during the next five years so that there will be no interruption of the institution's services.

Triboro Hospital "Open for Business"

The first patients were admitted to the new \$3,500,000 Triboro Tuberculosis Hospital, Queens, N. Y., on January 2. Two of the 12 patients admitted were transferred from Queens General Hospital and 10, from Kings County Hospital. Some 300 patients will be admitted by the end of the month.

After leaving the supply room, and before entering the sterile field of the operating table, the sutures in their hermetically sealed glass tubes are sterilized by being immersed in a solution of 70% Pure Ethyl Alcohol. The tubes remain in the sterile solution of the suture jar for a minimum of 30 minutes.



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- ☐ Surgical Soap Preparation
- ☒ **Sutures Sterile Solution**
- ☐ Therapeutic Nerve Block



Institutes on Purchasing and Accounting to Be Inaugurated by A.H.A.

Two new institutes, one on hospital purchasing and the other on hospital accounting, are to be conducted by the council on administrative practice of the American Hospital Association.

The course in hospital purchasing will be held at Johns Hopkins University, Baltimore, from June 9 to 14, inclusive, according to an announcement last month by Arden E. Hardgrove, chairman of the committee on purchasing. The institute will be conducted with

the cooperation of the university and the Baltimore Hospital Conference. The registration fee is \$10 and board and room in the university dormitory are available for \$20 for the period. Applications for admission to the institute should be sent to P. J. McMillan, secretary of the committee on local arrangements, Baltimore City Hospitals. Registration is to be limited to 75. Administrators of hospitals and hospital purchasing agents will be given first consideration.

The institute on hospital accounting will be held at Indiana University, Bloomington, and will also run from

June 9 to 14. It will be under the direction of Graham L. Davis, chairman of the council on administrative practice, who is also consultant on hospitals to the W. K. Kellogg Foundation, Battle Creek, Mich.

Morning and afternoon lectures and seminars by recognized experts on hospital accounting will be followed by round table conferences in the evening on questions arising out of the lectures and seminars of the day and on problems in general as related to the various aspects of hospital accounting.

Persons eligible for registration include administrators, assistant administrators, business managers, accountants, bookkeepers or others who have equivalent responsibilities in any hospital located in the United States or Canada.

Persons interested in registering for the institute on accounting should communicate with Stanley A. Pressler, associate director, institute on hospital accounting, Indiana University, Bloomington, for details. It is planned to limit the registration to 100.

ON THE RECEIVING LINE AGAIN

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2. COMFORT. Finished Terrazzo is *easy to walk on*. It is less slippery than any waxed surface. Furthermore, Terrazzo can save you enough money to acousticate your ceiling, thus giving you a very low noise level.

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5. DEPENDABLE INSTALLATION. This Association's objective is to see that your Terrazzo installations *turn out exactly as you want them*. Write us today for complete information on the above points or see our advertisement in Sweet's Catalog for basic technical data.

De Paul Sanitarium, New Orleans, La. Architects: Andry & Feitel of New Orleans.

THE NATIONAL TERRAZZO AND MOSAIC ASSOCIATION

Public Inspects New Additions

Two hospitals recently held open house to allow the public to inspect newly completed additions. More than 1000 people were conducted through the new \$153,000 wing of the Peninsula General Hospital at Salisbury, Md., on December 30. The new wing more than doubles the capacity of the institution, bringing it from 74 to 177 beds. On January 6 Luther Hospital, Eau Claire, Wis., opened a wing. In addition to maternity and nursery departments, the new building accommodates additional private rooms, a diet kitchen, a boiler room and laundry.

Michigan Plan Pays Out \$1,000,000

Payments to hospitals for service rendered to subscribers of the Michigan Hospital Service plan passed the million dollar mark on December 31. A record enrollment of 83,574 subscribers for the last three months of 1940 was also reported. During December three hospitals, Thomas Huizing Memorial Hospital, Zeeland; Hillsdale Community Center, Hillsdale, and Mellus Hospital, Brighton, joined the Michigan plan.

Perth Amboy Given New Nursery

A gift from the Perth Amboy Day Nursery Association, Perth Amboy, N. J., in memory of Mrs. Clara L. Bawdon, has made possible the construction of an addition to the nursery of Perth Amboy General Hospital. The present bassinets capacity of 18 will be increased to 30.

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and Handles

Announce Sale of Easter Seals

The National Society for Crippled Children and affiliated state societies have announced that they will again offer for sale Easter seals to aid in financing their work. The work of the societies is preventive as well as remedial in its purpose.



New Tumor Clinic Established

A \$15,000 tumor clinic was dedicated by Henrotin Hospital, Chicago, on January 19, marking the completion of the installation of a 220,000 volt deep therapy machine in a specially constructed lead-lined room. Henrotin is the eighth general hospital in Chicago to establish such a clinic. Dr. Henry L. Jaffe has been named director.

Refresher Course for Librarians

A six day refresher course for medical record librarians will be held at the Fairmont Hotel, San Francisco, on March 3 to 8, inclusive, under the direction of the Northern California Chapter of the American Association of Medical Record Librarians and the Association of Western Hospitals. There will be morn-

ing and afternoon lectures and evening round table discussions. Among those expected to participate in the teaching are Howard Burrell, attorney; Dr. Malcolm T. MacEachern; Sister Mary Patricia, administrator, St. Mary's Hospital, Duluth, Minn.; Dr. Thomas R.

Coming Meetings

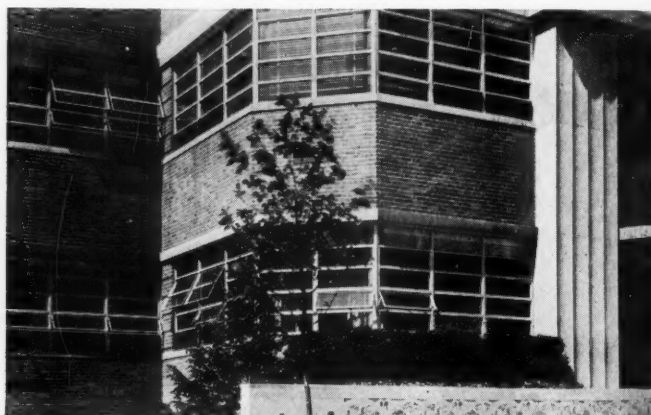
Feb. 15-16—Mid-Year Conference of Presidents and Secretaries of State Hospital Associations, Drake Hotel, Chicago.
Feb. 17-18—Congress on Medical Education and Licensure, Chicago.
Feb. 19-20—National Methodist Hospitals, Homes and Deaconess Association, Chicago.
Feb. 27-March 1—Texas Hospital Association, Adolphus Hotel, Dallas.
Feb. 28-March 1—Arizona Hospital Association, Tucson.
March 1—Texas Conference, Catholic Hospital Association, St. Paul's Sanitarium, Dallas.
March 3-6—Association of Western Hospitals, Fairmont Hotel, San Francisco.
March 4—Association of California Hospitals, San Francisco.
March 7—Alabama Hospital Association, Montgomery.
March 10-12—American College of Surgeons, Sectional Meeting, Hotel Nicolle, Minneapolis.
March 11—Massachusetts Hospital Association, Boston.
March 12-14—New England Hospital Assembly, Hotel Statler, Boston.
March 17-19—American College of Surgeons, Sectional Meeting, William Penn Hotel, Pittsburgh.
March 26-28—American College of Surgeons, Sectional Meeting, Utah Hotel, Salt Lake City, Utah.
April 3-4—Kentucky Hospital Association, Louisville.
April 7—Tennessee Hospital Association, Nashville.
April 16—Louisiana Hospital Association, New Orleans.
April 16-18—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.

April 17-19—Southeastern Hospital Conference, New Orleans.
April 21-23—Iowa State Hospital Association, Fort Des Moines Hotel, Des Moines.
April 24-25—Mid-West Hospital Association, Kansas City.
April 24-26—Carolinas-Virginias Hospital Association, Greenville, S. C.
April 25-26—Washington State Hospital Association, Tacoma.
April 29-May 1—Ohio Hospital Association, Desler-Wallick Hotel, Columbus.
May 7-9—Tri-State Hospital Assembly, Stevens Hotel, Chicago.
May 12—Mississippi State Hospital Association, Biloxi.
May 15-17—New Jersey Hospital Association, Atlantic City.
May 21-23—Hospital Association of the State of New York, New York City.
Aug. 17-19—National Hospital Association, Chicago.
Sept. 12-14—American Protestant Hospital Association, Atlantic City, N. J.
Sept. 13-15—American College of Hospital Administrators, Atlantic City, N. J.
Sept. 15-19—American Hospital Association, Atlantic City, N. J.
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.
Oct. 23-24—Missouri Hospital Association, St. Louis.
Nov. 13-14—Kansas Hospital Association, Topeka.
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.
Dec. 4—Utah Hospital Association, Salt Lake City.

Ponton, editor, *Hospital Management*, and the following record librarians: Elizabeth Cooper, Clarence E. De Lear, Grace Ethier, Ivy Hubert, Anna P. Kennedy, Alice G. Kirkland, Laura P. Martin, Norma Swanson and Marjorie Larson.

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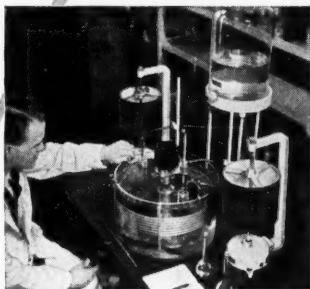
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Names in the News

Administrators

ALBERT SCHEIDT, assistant administrator of Michael Reese Hospital, Chicago, was unanimously named superintendent of Miami Valley Hospital, Dayton, Ohio, by the board of directors. He succeeds DR. E. R. CREW, who resigned recently, and is the first nonmedical superintendent in the history of the hospital. Prior to his appointment as assistant administrator at Michael Reese, Mr. Scheidt was executive director of the Chicago Hospital Council.

JENNY HART SULLIVAN, superintendent of Bound Brook Hospital, Bound Brook, N. J., left that position on January 20 to become administrator of Ossining General Hospital, Ossining, N. Y.

DR. J. A. KATZIVE, assistant director of Mount Sinai Hospital, New York City, has been appointed superintendent of Mount Zion Hospital, San Francisco, to succeed A. G. SAXE.

VAN C. ADAMS, formerly superintendent of Springfield City Hospital, Springfield, Ohio, has been appointed to fill the position of the late DR. WALTER LIST

as head of Jewish Hospital, Cincinnati. R. E. RAPER, administrator of Methodist Hospital of Central Illinois, Peoria, Ill., will succeed Mr. Adams at the Springfield hospital.

MARY L. WHITTAKER, who has held the post of superintendent of Margaret Pillsbury Hospital, Concord, N. H., for seventeen years, resigned recently. EDITH D. PAYNE, principal of the school of nursing, and LURLINE E. OLSEN, science instructor in the school, also resigned. ANNA C. N. NELSON, R.N., has been appointed head of the nursing school to succeed Miss Payne. FREDERICK A. SHARP, formerly head of White Plains Hospital, White Plains, N. Y., has been named as Miss Whittaker's successor.

JACOB GOODFRIEND, assistant director of Montefiore Hospital, New York City, will assume the duties of administrator of Jewish Hospital, Philadelphia, on March 1. Mr. Goodfriend joined the staff of Montefiore Hospital thirty years ago and was appointed assistant director in 1929. He will succeed the late ALFRED MAYER at Jewish Hospital. NEWMAN BILLER, administrative assistant of Bronx

Hospital, N. Y., will fill Mr. Goodfriend's position at Montefiore Hospital.

E. C. H. PEARSON, administrator of Duval County Hospital, Jacksonville, Fla., left that institution to become head of Good Samaritan Hospital, West Palm Beach, Fla., succeeding DR. W. LAWSON SHACKELFORD. The new superintendent of Duval County Hospital is DR. JOHN L. BURGAN.

A. D. KINCAID JR. has resigned as superintendent of Southside Community Hospital, Farmville, Va., to go to City Memorial Hospital, Winston-Salem, N. C., as assistant to DR. J. B. WHITTINGTON.

DR. HERBERT MCC. WORTMAN has been appointed director of Mountainside Hospital, Montclair, N. J. Doctor Wortman, who served as assistant at the hospital under DR. CHARLES H. YOUNG, has been filling the post of acting administrator since Doctor Young's appointment as head of the Jefferson Hospital, Birmingham, Ala.

NETTIE FITCH, superintendent of Paulina Stearns Hospital, Ludington, Mich., since 1929, resigned recently because of ill health. RUTH SAFE, head nurse, will serve as head of the hospital until Miss Fitch's successor is appointed.



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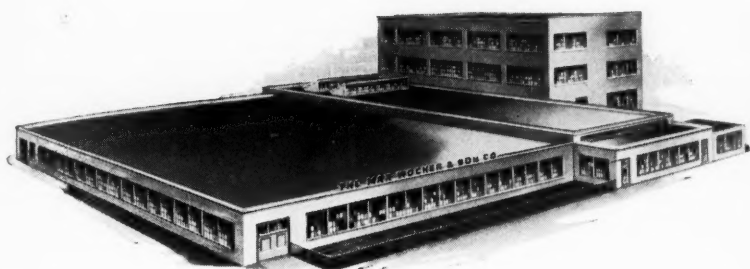
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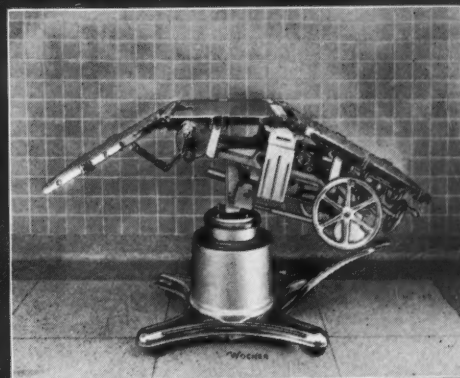
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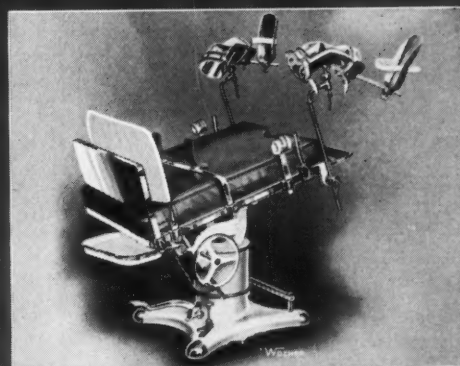
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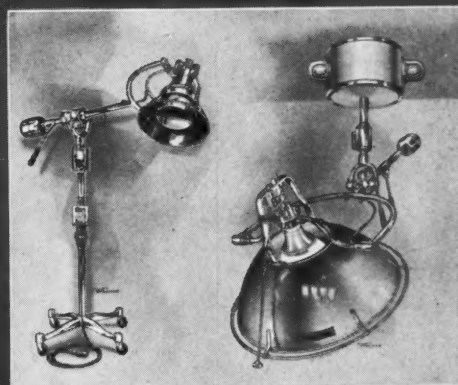
Vol. 56, No. 2, February 1941



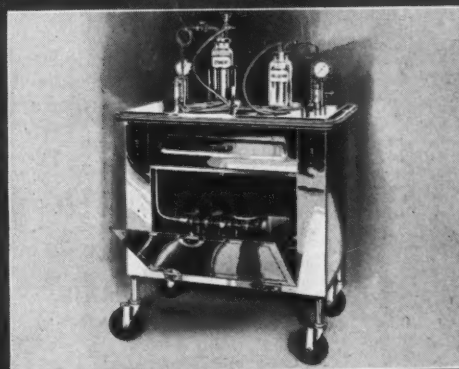
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PRINCETON
ETHER VAPOR OUTFIT

WILLIAM E. P. COLLINS has been named superintendent of Staten Island Hospital, Staten Island, N. Y., to succeed LOUIS H. PUTNAM, who resigned last October. Prior to this appointment, Mr. Collins served for five years as assistant superintendent of Lenox Hill Hospital, New York.

DR. GEORGE A. ELLIOTT, for the last seven years assistant superintendent of Connecticut State Hospital, Middletown, Conn., has resigned that position to take over the duties of superintendent of the Brattleboro Retreat, Brattleboro, Vt.

M. LOUISE SANFORD, R.N., superintendent of Addison Gilbert Hospital, Gloucester, Mass., tendered her resignation on January 10. Miss Sanford joined the hospital staff in 1925 as assistant superintendent and remained for four years. In 1934 she returned to the hospital and in 1936 succeeded MARTHA J. AVARD as superintendent.

RUTH PALMER, matron of White Pine General and County Hospital, Ely, Nevada, for the last seventeen years, resigned recently. Mrs. T. G. WHEELWRIGHT will serve as matron until Miss Palmer's successor is selected.

DR. JOSEPH O. WEILBAECHER JR. has been named acting director of Charity Hospital, New Orleans, to succeed DR.

ROY WRIGHT, who resigned on January 1. DR. CHARLES B. ODOM was named associate director. Both Doctor Weilbaecher and Doctor Odom have been assistants to Doctor Wright.

DR. EDWIN L. CROSBY has been appointed to succeed JOHN RANSOM as assistant director of Johns Hopkins Hospital, Baltimore. Doctor Crosby has been statistician and supervisor of records at the hospital since 1937 and associate physician in preventive medicine since 1939. He has also been special consultant in the U. S. Public Health Service since 1937.

M. LOUISE HOOD, superintendent of Florence Crittenton Hospital, Detroit, has retired after twenty years of service to the institution.

CAPT. JOHN A. LINDER has been appointed superintendent of Perth Amboy Hospital, Perth Amboy, N. J.

Department Heads

EMMA L. MONTGOMERY, R.N., has resigned as superintendent of nurses of Cortland County Hospital, Cortland, N. Y. Miss Montgomery was appointed night superintendent of nurses in 1913 and superintendent in 1929.

LAURA M. SAUER, R.N., director of nurses of Homeopathic Hospital, Read-

ing, Pa., resigned recently to become director of nurses at West Baltimore General Hospital, Baltimore.

MARY R. MCCARTHY, R.N., supervisor of nurses and x-ray technician of Bessie Burke Memorial Hospital, Lawrence, Mass., resigned on January 1. She had been associated with the hospital for eight years.

MRS. KATHARINE PEILEKE, formerly of University of Pennsylvania Hospital, Philadelphia, has been appointed executive housekeeper of West Jersey Homeopathic Hospital. She succeeds Mrs. Doris Dungan, who resigned to fill a similar post in Hartford, Conn.

Deaths

DR. PAUL NICHOLAS LEECH, chairman of the council on pharmacy and chemistry of the American Medical Association, died January 14 of a cerebral hemorrhage.

Three Floors Added to Hospital

An enlargement of Mount Sinai Hospital, Chicago, was announced by Morris Kurtzon, president, at the annual meeting of the hospital on January 16. Building contracts have been let and three new floors comprising a children's department, private rooms and a surgery will be added to the institution.

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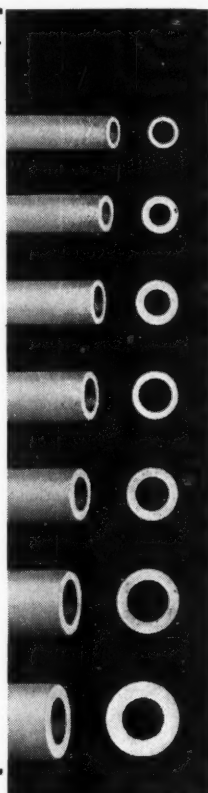


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2885	3/16"x1/16"	48	47
2886	1/4"x1/16"	36	38
2887	1/4"x3/32"	24	24

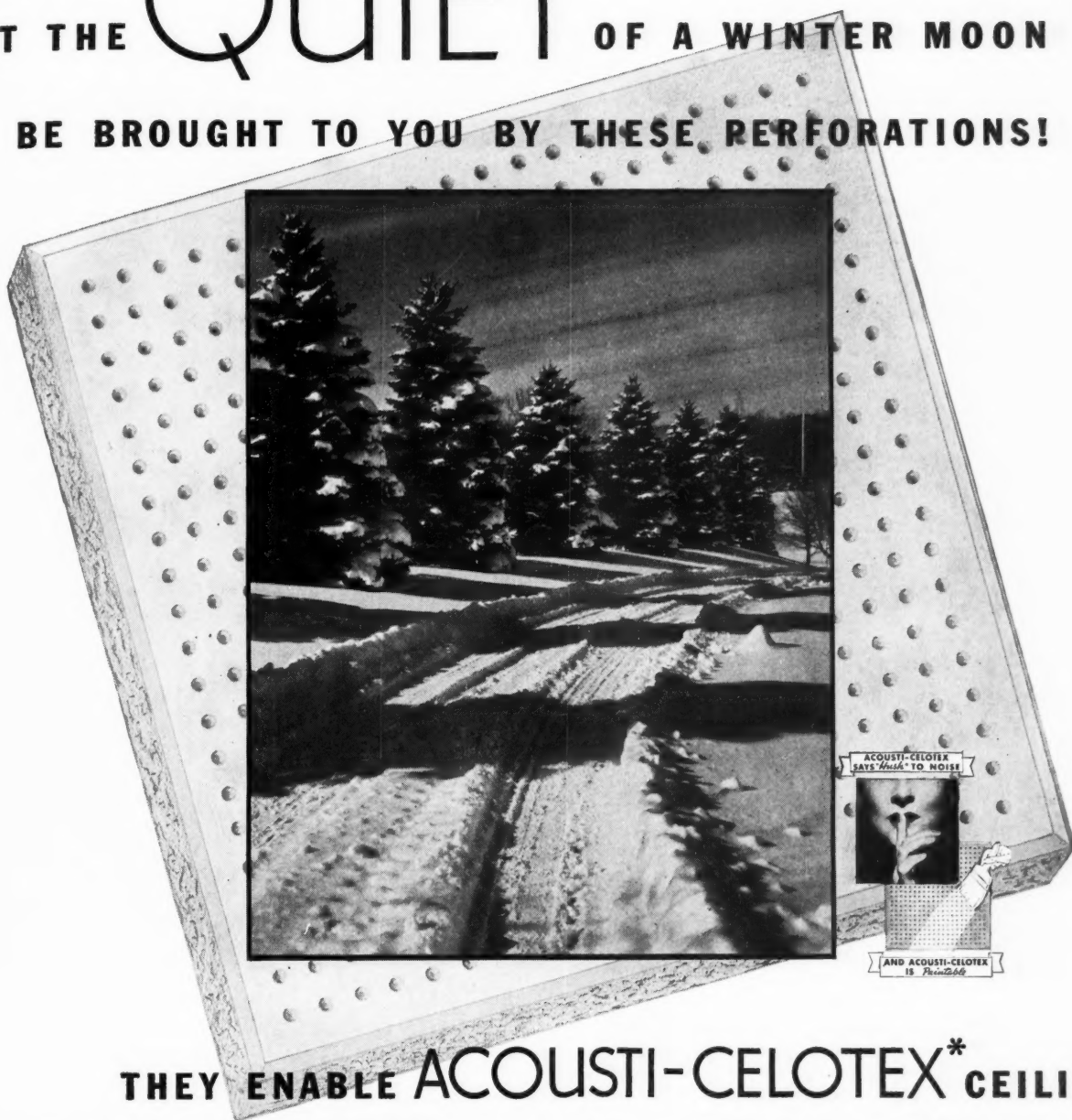


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Trade News

Safe Safety Pin

• A new safety pin that is said to eliminate numerous hazards is now being offered by the Safe Safety Pin Corporation of America, 647 Santa Fe Avenue, Los Angeles. When opened, the point does not protrude at an angle but is forced back into a protective groove by a counter-acting spring. The danger of the pin's being accidentally forced open while in use is also eliminated.

Uniforms for All Occasions

• A catalog illustrating various types of nurses', doctors', interns', technicians' and maids' uniforms has recently been published by Stein Uniform Company, Baltimore. Included in the booklet are a measurement chart and instructions for ordering.

Pyridoxine in Two Forms

• E. R. Squibb & Sons, 745 Fifth Avenue, New York, is now supplying pyridoxine hydrochloride in miniature capsules (microcaps) and in aqueous solution. The capsules are administered orally and the solution, by the subcutaneous, intramuscular or intravenous

route. One mg. microcaps are supplied in vials of 50 and 10 mg. capsules, in boxes of 20. The solution comes in 5 cc. rubber capped vials containing 25 mg.

Preserving Microfilms

• The latest filing development of Remington Rand Inc., Buffalo, N. Y., is a storage cabinet that is especially designed for long period preservation of microfilm records. Nine of the 10 drawers of the file hold 900 standard 16 mm. film storage boxes. The tenth contains a stabilizing chemical which maintains a 51 per cent humidity within the cabinet, which is necessary to preserve the film.

Sipping Straws

• Stone Straw Corporation of Washington, D. C., has recently designed a sipping straw made of a clear, transparent cellulose material that can be discarded immediately after using. The straws are bent a third of the way down at a 45 degree angle. They will not break or crack with ordinary usage, the manufacturer states, and any liquid, either hot or cold, can be sipped through them.

Ice Cube Cutter

• Two new models of ice cube cutters have been developed by Thermo Cuber Company, 3268 West Grand Avenue, Chicago. The cubes are cut from block ice by heat transferred from water at from 60° F. to 180° F., passing through small metal tubes. Contact of the heated tube grid cuts the cubes quickly, safely and quietly.

Continuous Cubicle Curtains

• The Capital Cubicle Company, 213 Twenty-Fifth Street, Brooklyn, N. Y., has developed a method of cubicle curtaining that is designed on a new principle wherein concealed hooks slide along an inverted concealed track. Corner bends permit a series of "rooms" to be curtained off with one continuous curtain to a section.

Improved Diagnostic Instruments

• Two new and improved instruments for the diagnosis of eye, ear, nose and throat diseases have recently been announced by Bausch and Lomb Optical Company, Rochester, N. Y. The May opthalmoscope features a new illuminated dial with magnified numerals; easier correction of refractive errors, and control of illumination. The Arc-Vue prism otoscope affords increased accessibility and magnification of the operative field.

THIS OXYGEN THERAPY "HANDBOOK"

helps hospital personnel




Many hospitals use this "Handbook" as a supplementary textbook in nurses' training. Other Linde services include motion pictures, technical advice, and instruction in the handling of oxygen.



THE "Handbook of Current Practices in Operating Oxygen Therapy Equipment" is full of up-to-date information on accepted practices for operating commonly used types of oxygen therapy apparatus. It is widely used as a reference book, and is particularly valuable in training hospital personnel in the mechanics of administering oxygen. In this way it is helping hospitals utilize to the fullest extent the economies of oxygen from large industrial-size cylinders.

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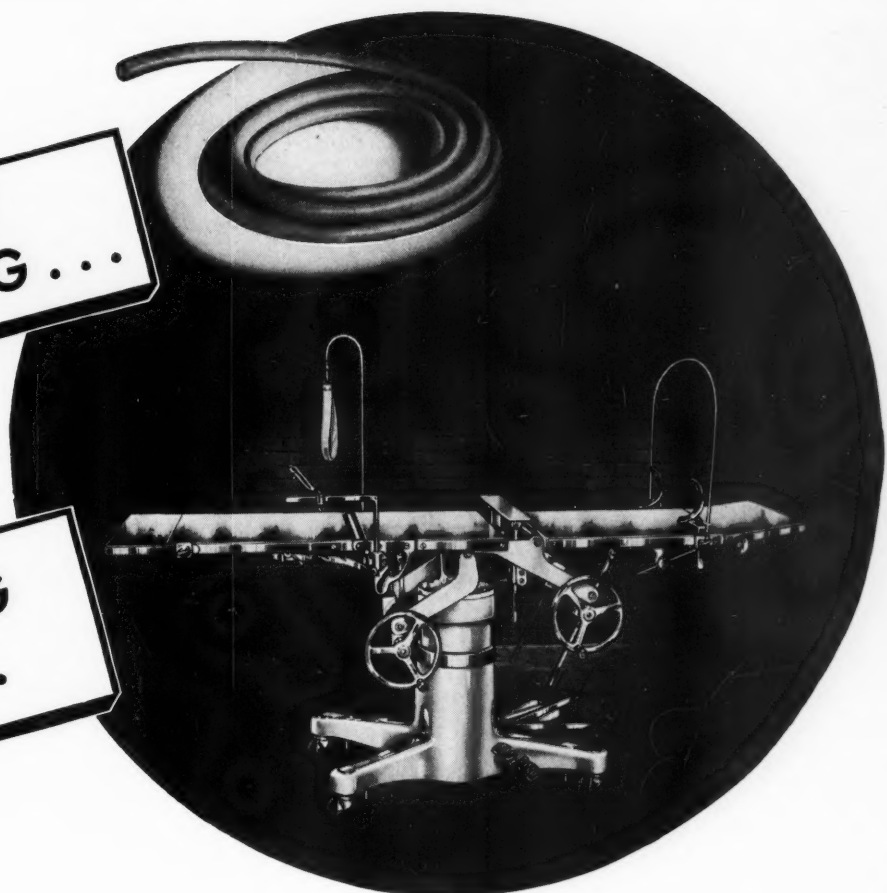
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Greaseproof Flooring

• A greaseproof asphalt tile flooring that is also alkali resistant has recently been announced by the building materials division of Armstrong Cork Company, Lancaster, Pa. It is said to be particularly suitable for installation in areas where there is danger of spilling oils, fats or greases. The new flooring is manufactured in 10 plain and 11 marbled colors.

Portable Electroencephalograph

• The Electro-Medical Laboratory, Inc., Holliston, Mass., announces the new junior electroencephalograph. The instrument is portable and simplified in operation. The selector switch is built into the unit.

Notes and News

• St. Marys Woolen Manufacturing Company, St. Marys, Ohio, has established a direct mill sales office in the Merchandise Mart, Chicago. The new office will be managed by M. E. Hawkins.

• R. J. Rehwinkel, vice president and general sales manager of the McCray Refrigerator Company, Kendallville, Ind., will take over the supervision and management of factory branches, succeeding J. W. Hart, who has been made treasurer of the organization.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.,
Arnold J. Lehman, M.D., and Harold Chase, M.D.,
Wayne University, Detroit.

Effect of Oral Bismuth

• The observations on the absorption, distribution and excretion of oral bismuth, which appeared in this column in the January issue, lead one to expect a definite antisiphilitic effect from sobisminol mass. Clinical studies by Scholtz, McEachern and Wood of Los Angeles of the spirocheticidal action have shown that oral medication with the preparation has a prompt and sustained effect. The median disappearance time of the spirochetes from the chancre is about five days. Involutional changes of the primary and secondary lesions take place rapidly and are completed in from ten to fourteen days. Cutaneous manifestations of late syphilis require a longer period for complete healing. A number of such observations establish this healing time at about five weeks. Serological improvement also compares favorably with bismuth by any route. In neurosyphilis relief from headache, lightning flashes and loss of appetite is experienced.—A. J. LEHMAN, M.D.

Vaginal Douches

• Savitz and his co-workers in Philadelphia have recently investigated colloidal kaolin and aluminum hydroxide gel as a cleansing vaginal douche. The patient is instructed to use 15 gm. of an aluminum hydroxide-colloidal kaolin mixture in 8 ounces (240 cc.) of water. After douching, the patient may use a rinse of several quarts of warm water. If continued action (mucus coagulating effect) is desired, the rinse may be applied several hours later. The douche may safely be repeated.

The pH of the mixture is about 7.0. It supplies neither acid nor alkali to the vaginal tract. It is a neutral, mucus coagulating, nontoxic and nonirritating substance. If acidity is desired therapeutically, it can be supplied by specific agents.

In cases of Trichomonas and monilia with marked tenderness that prohibits immediate treatment, the use of the douche eases the irritation.—CARL C. PFEIFFER, M.D.

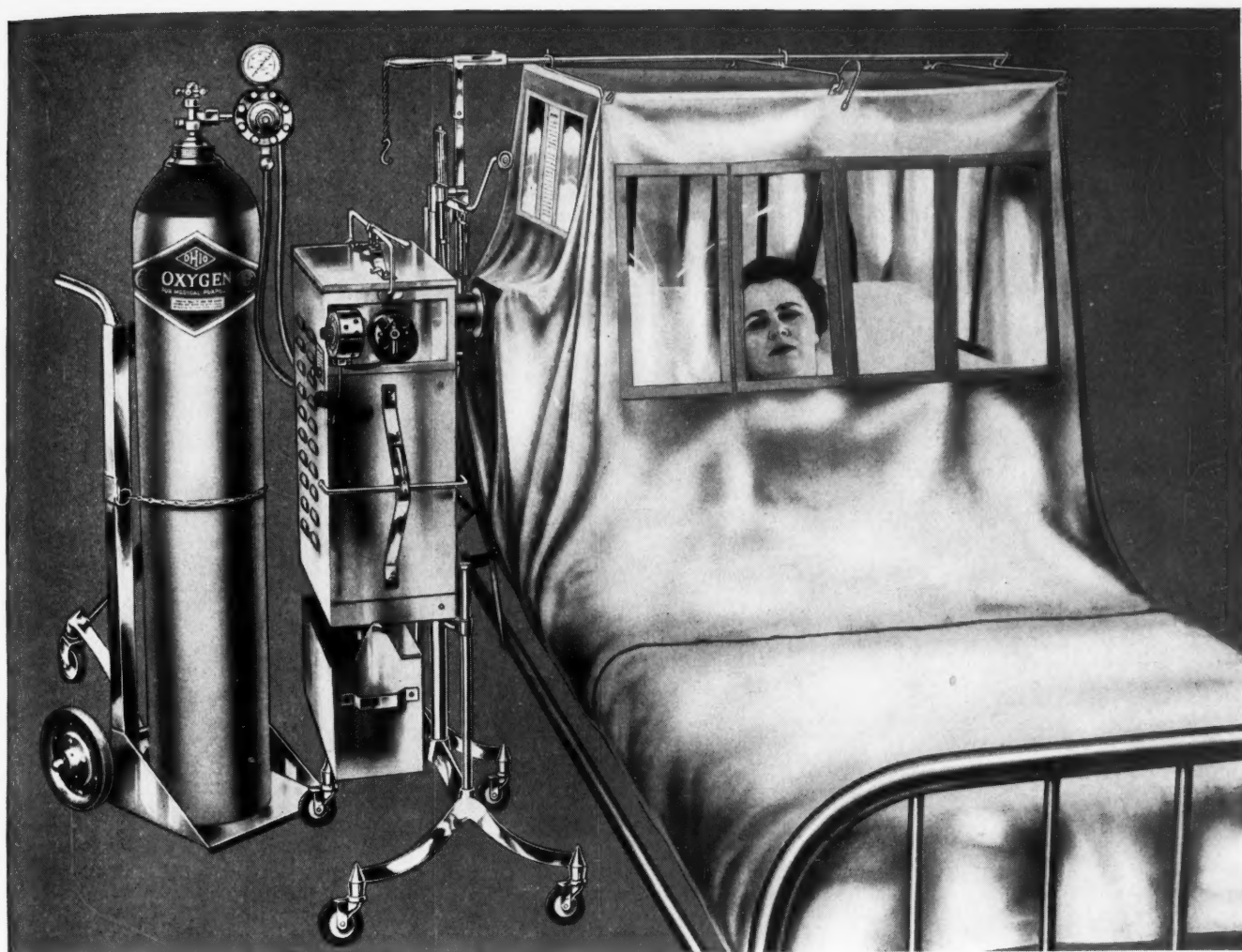
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Books on Review

LEGAL GUIDE FOR AMERICAN HOSPITALS. By Emanuel Hayt and Lillian R. Hayt (in collaboration with the council on government relations, American Hospital Association). New York: Hospital Textbook Company, 1940. Pp. 608. \$5.

This long looked for work on hospital administration by capable authors is divided into 27 chapters covering every conceivable angle of hospital legal problems. Each main topic is analyzed with explanatory subtitles. The index of topics is complete. Main topics begin the list and incidental topics and states follow in clear subtitles. There is adequate cross-indexing.

The cases cited are up to date; appeals have been carefully and intelligently followed and systematically noted. When new decisions were handed down the authors did not neglect to note them even after the manuscript was in proof. These additional cases can be found in the footnotes with notations.

No statement is made without giving the authority for it. The explanations are clear, illustrative and vivid. When there are exceptions to the general rule, these

are made and explained in a systematic manner. Digests of statutes of the different states are ample and carefully annotated.

The treatise is not based entirely on laws and decisions but brings in discussions by experts on the various subjects. Scholarly articles are quoted.

Other important topics, such as zoning statutes, kinds of corporations, amendments to charters, standards, licensure and visitation of hospitals, regulations, tax exemption, donations, insurance plans, hospital records, immunities, nursing law, public health laws, lien laws, workmen's compensation and labor relations, all are treated from the standpoints of both private and governmental hospitals.—SISTER M. ANN JOACHIM.

WHAT IT MEANS TO BE A DOCTOR. By Dwight Anderson. New York: Public Relations Bureau, Medical Society of the State of New York, 1939. Pp. 96. \$1.

It would appear that this small book would be of inestimable value to a parent who is considering a medical career for his son or for the young man

who is considering a medical career. Only short references are made from time to time to hospital problems and these, as a rule, are used to illustrate special points. There is a short résumé of the history of medical schools and the reduction in the number of these schools as a result of careful study.

It is interesting to note that a layman, even with the author's connections, could have had such an insight into the preparation of the medical student for practice.—A. K. HAYWOOD, M.D.

DIETETICS. By Alide Frances Pattee. Mount Vernon, N. Y.: A. F. Pattee, 1940. Pp. 868.

Miss Pattee's new edition of her book resembles her other editions inasmuch as she has followed closely the last "Curriculum Guide for Schools of Nursing" issued by the National League of Nursing Education. Therefore, this book will have a definite appeal to nurses, dietitians and physicians. Food value tables are complete and contain the newest values available in vitamins.

Physicians who are specialists in their individual field personally prepared the description of their own procedures in treatment of diseases and particularly emphasized the diets used. The last section of the book includes the preparation of diets for both well and sick individuals.—RUTH M. KAHN.

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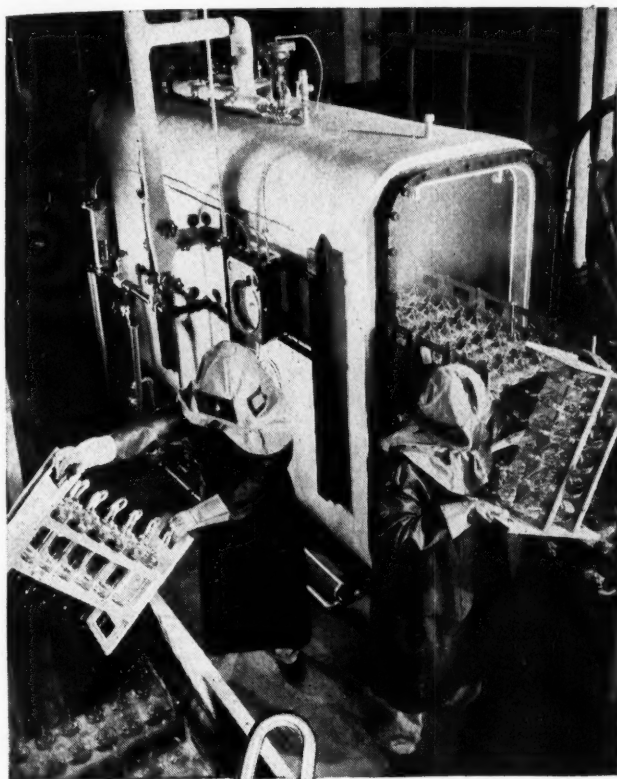
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Reader Opinion

Hospital Racketeers

Sirs:

When I read the article called "Hospital Thieves We Have Known" in the July issue I wondered why it was that just such an article had not been written before.

For the last twenty years I have been working as an executive in half a dozen hospitals, as well as other institutions, and have been amazed at the amount of dishonesty that is rife in these places. No one seems to mind or bother about it and yet most hospitals have deficits that are caused by nothing but poor administration and thieving among employees.

Some of the points brought out in the article were new to me, but one question that was not mentioned is the lazy or dishonest superintendent who turns his position into a regular racket.

The superintendent who has his home, food and laundry as part of his salary often costs the hospital thousands of dollars a year, a fact that the trustees seem unable to realize. I have worked for superintendents who live in houses on

the hospital grounds and the amount of food that goes over to their homes for themselves and their guests is staggering. Furthermore, the load of laundry that is sent over to the hospital each week includes silk hose, dresses and shirts. Laundry is mailed to the superintendents' children away at school and the hospital pays the postage.

In addition, these superintendents require endless service from hospital employees. For example, maids and porters are expected to clean their houses and cars, to run errands for the family and, if the hospital has a garden, to pick vegetables and flowers for the superintendent's household.

Then there are the gifts that employees and salesmen are expected to present to the superintendent on birthdays and at Christmas.

Every time a member of the superintendent's family has a cold he is hospitalized and always demands constant attention. A special nurse is never hired and the whole staff has to run around and wait on him while paying patients have to wait for the care they are entitled to.

Superintendents of nurses, when there is little supervision of their work or actions, often go in for this kind of game also. They are just as bad or worse than the superintendents.

If this kind of racketeering went on in hotels they would soon be in bankruptcy; hotels cannot appeal for donations to cover their deficits.

All superintendents are not like this, I know, but I am afraid that about 60 per cent of them are, especially in the hospitals of less than 250 beds. I wonder what can be done about it. To me, it seems dreadful to think of all this dishonesty, especially in a hospital which is supposed to work for the good of mankind.—M. T.

Literary Clubs Launched

Sirs:

Your December issue containing my article on "Literary Clubs for Patients" came as a pleasant surprise. Since our correspondence began, Doctor Griffith of Veterans' Administration has become interested in the idea of literary clubs and has arranged to bring it to the attention of all of the veterans' facilities. This is certainly a good beginning for a new idea.

Nathan Blackman, M.D.

Worcester State Hospital,
Worcester, Mass.



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